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Citation: Ashburner, C.H. (2005). Person-centered care : using systemic and psychodynamically informed action research. (Unpublished Doctoral thesis, City University London)

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PERSON-CENTRED CARE: USING SYSTEMIC AND PSYCHODYNAMICALLY INFORMED ACTION RESEARCH

by

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A thesis submitted in accordance with the requirements for the degree of

Doctorate in Health

St Bartholomew School of Nursing and Midwifery, City University

July 2005

Excerpt from Waiting for the Telegram by Alan Bennett (1998). Part of the Talking Heads Series.

The speaker is an old lady in a wheelchair. She has a rug over her knees. The background is plain and uncluttered. Sometimes she is parked by a radiator, sometimes by a window or at the end of a bed.

Violet is spoken by Thora Hird.

That Devon was giving me a bath. I said , 'Them's never my legs'. She said 'Whose legs do you think they are?' I said, 'Well, you never know in this place. I've had somebody else's teeth before now. And this frock isn't mine. Tangerine doesn't suit me. Where's that green little frock?' She said, 'Hilda kept wetting herself in it and its gone funny.' Francis wouldn't have put me in this frock. Only he wasn't there.

She's putting me back on the bed and I said, 'Well I've learned one thing, I'm not Betty Grable.' She says, 'Who's she?' No wonder your talking goes……even when you get it right they think you're barmy. Francis knows all the old film stars….Betty Grable….her that sings and that one with the cig and her hair up….bit of a madam…Bette Davis.

Anyway I'm sitting in bed and they all waltz in with this cake. Turns out it is my birthday. I'm ninety something …… I don't know they did tell me. Candles. Tasted like candles did the cake. Anyway I had to reckon to be… pleased (*She pretends to smile)*….Kept saying a few years more and I'll be getting the ….. now then…. lad comes on a bike ….folks stood on the door weeping…telegram. Her on the horse at the end of the picture, she sends it to you apparently. Queen.

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ACKNOWLEDGMENTS

I am indebted to so many people who have helped me along the way. First, to thank the research participants who have been instrumental in shaping and developing nursing practice. I appreciate everyone's contribution but in particular the time, energy and commitment given by participants in support of the various endeavours reported in the thesis.

My academic supervisors Julienne and Angela deserve a special mention for their expertise, invaluable support and dogged determination.

Jackie, Debs, Anne, Jennie, Barbara, Sally, Cheryl and Rachel are colleagues who have been so encouraging.

Special thanks to Sheila, Marsha, Frances, Eugene, Neil, Maureen and Eileen who kept me going.

To thank the Central and East London Educational Consortium, City University and the Directors of Nursing within the NHS Trust for supporting this doctoral work over the past seven years.

Finally, to say thank you to Emma, Mary and Clare for being such good friends.

ABBREVIATIONS

CARP	CELEC Action Research Project: Care for Older People
CELEC	Central and East London Educational Consortium
CNO	Chief Nursing Officer
DCM	Dementia Care Mapping
DHealth	Doctorate in Health
ICU	Intensive Care Unit
HAS 2000	Health Advisory Service 2000
NHS	National Health Service
NSF	National Service Framework
NVQ	National Vocational Qualification
PAMS	Professions Allied to Medicine
PCT	Primary Care Trust
QUIS	Quality Interaction Schedule
RCN	Royal College of Nursing
SNMAC	Standing Nursing and Midwifery Committee
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
WIB	Well-being and Ill-Being Score used in Dementia Care Mapping

DECLARATION

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Executive Summary

PERSON-CENTRED CARE: USING SYSTEMIC AND PSYCHODYNAMICALLY INFORMED ACTION RESEARCH

Current health and social care policy advocates the development of person-centred care (Department of Health, 2000, 2001a, 2004). This professional doctorate describes two practice development initiatives fostering person-centred approaches to nursing care through action research. All research activities took place within the context of a National Health Service (NHS) general hospital within an economically deprived and ethnically diverse inner city borough. Person-centred approaches were based upon the innate capacities of human growth and creativity nurtured through positive relationships with service users, staff, family members and the wider community. Much of the professional debate concerning person-centred care remains largely conceptual and this work translates the ideas of person-centredness into the reality of everyday nursing practice. The practical application or 'how to' establish person-centred approaches in nursing is the contribution this doctorate makes to professional knowledge.

The development of person-centred care in practice was built upon three main interventions: biographical interviews with service users and family members, clinical supervision for nurses and action learning for nurse managers. These small group experiential interventions were facilitated in a systemic and psychodynamically informed way, in which attention was given to the emotional constraints to organisational change and development. This way of working produced positive outcomes for service users, family members and staff including:

- Positive changes reported through semi-structured interviews with service users, staff and family members
- Reduced staff sickness and agency nurse usage
- Improvements in the quality of care evaluated through a variety of clinical audits

The findings of this work identify the necessary systems of staff development (clinical supervision and action learning) required to build more enriched clinical environments in support of the delivery of person-centred care. In addition, the approach to action research adopted by the researcher can be recommended to other health and social care practitioners striving for more person-centred services.

Preface

DEVELOPING NURSING PRACTICE

This thesis describes how as a researcher I have worked to establish more humane, compassionate and thoughtful approaches to nursing practice: in essence, to create and develop person-centred ways of working in nursing. An overview of this endeavour will be discussed in the preface as three distinct developmental stages reflecting my personal development as a researcher. The Doctorate in Health (DHealth) consists of five practice based elements: preface, case study, review of the literature, research report and dissemination artefacts. This preface will explore the links between the varying elements and development of this work over the past seven years.

Each element required for the DHealth occurred during three distinct developmental stages from 1997-2004. The stages outlined in this preface represent the chronological development of my understanding and practice of person-centred care. Stage one (1997-2000) represents my earliest doctoral work in developing systems of clinical supervision for general nurses and is described in the case study element of the DHealth. In 2000, there was a shared overlap in research activities between stages one and two. Stage two (2000-2003) represents the mid phase of my development predominately spent developing person-centred practice in a NHS continuing care unit in a full-time action research role. This stage is described in the research report and is the most substantive element required for the DHealth. The final phase in 2004 reflects the honing of my academic skills and in particular my writing skills completing a literature review on person-centred care, publication of a peer reviewed paper (submitted as the dissemination artefact) and preparing the doctorate for submission. The completion of the literature review at the end of the doctoral research process (as opposed to the start of the project) in my experience reflects the hectic realities of changing practice, the open agenda and emergent nature of action research and the unique personal research journey described within this work. In August 2004 I took up post as a consultant nurse for older people, returning to the clinical challenges of improving care for older people.

There are three main threads integral to all the elements contained in this portfolio of practice focused initiatives:

1. Working with nursing staff, patients and family members to support improvements in practice through action research.

2. Working in a psychodynamically way to 'surface' issues and explore the 'hidden picture' of organisational dynamics, projective identification and less conscious emotional responses.

3. Exploring the issues and problems related to local implementation of national health policy guidelines and standards

These three threads reflect the purpose and guiding principles in this work. This practice development journey is most simply described in three stages and illuminates my growth and development from 1997 - 2004.

1.0 Stage one of my research development - Establishing clinical supervision for general nurses (1997-2000)

This stage is described in the case study element of the DHealth portfolio and evaluates the development of psychodynamically informed group clinical supervision for general nurses in an acute hospital. In the mid 1990s guidance from both the Department of Health (1993) and the UKCC (1996) recommended the development of non managerial clinical supervision for nurses. Working with this national guidance and in recognition of local need, I led an initiative to establish group clinical supervision for 52 nurses (F, G, H, I grade) using experienced external supervisors (n = 11). An innovative approach to clinical supervision was adopted using a supervision model from psychotherapy and counselling. This work represented the translation of supervisory practices drawn from other professional groups into nursing and warranted evaluation. The supervisors had a variety of backgrounds e.g. social work, nursing education and counselling, but all worked in a psychodynamically informed way. Supervision for the supervisors was provided by a psychotherapist who fostered a particular orientation to understanding organisational

dynamics underpinned by the theoretical work of the psychoanalyst Melanie Klein (Obholzer & Zagier Roberts, 1994). During this time I completed a Master's course in the application of psychoanalytical ideas to organisational consultancy at the Tavistock Centre and this programme has been highly influential in my approaches to practice development and organisational change.

The research participants were clinical supervision group members, supervisors and nurse managers who worked over four years to ensure the sustainability of this approach. Participants described how this initiative did bring 'something new' to nursing in which feelings were acknowledged, confidence grew, isolation was reduced and support provided in a crisis. However, not all participating nurses were comfortable with this initiative and difficulties were encountered with fragmented attendance at supervision sessions. Other findings suggest that whilst having no impact on staff turnover, clinical supervision may contribute to a reduction in staff sickness (Ashburner et al., 2004a).

The development of clinical supervision took place when I was working as a senior nurse for education, research and practice development at a local NHS Trust. The time afforded to research activities versus other role activities was restricted due to competing work priorities. In order to focus more fully on research activities, I took up a full-time action research post to improve care for older people within the same organisation in 2000. Drawing upon my experience in stage one, I was interested in exploring how group clinical supervision could be used to support changes in actual clinical care. In light of this case study, I sought a more focused research role to develop an in-depth understanding of the relationship between clinical supervision and quality of care.

1.1 Stage two of my research development - Developing person-centred care as an action researcher (2000-2003)

This stage is reflected in the largest element in the DHealth portfolio and reports on the findings from a three year action research study to develop person-centred care for older people living in an NHS nursing home. The study describes how to develop person-centred care in everyday clinical practice. This work provides information from an NHS front line service on the local implementation of policy recommendations contained in the National

Service Framework (NSF) for Older People and the issues surrounding modernising and changing NHS services for older people (Department of Health, 2000; Department of Health, 2001a). The local context of this study was a unit with a staff group who felt neglected and maligned by 'outsiders', with evidence of low standards of care and an impoverished care environment. The impoverishment of this NHS continuing care service was reflected in a dirty physical environment with smells of incontinence, poor quality of interpersonal communication, routine, de-personalised care for residents and poor working relationships between staff. I described the environment as a 'waiting room for death'. The challenges for me as an action researcher lay in trying to understand my own reactions and responses to participants in order to work in a reflective, self aware and helpful way.

Six action cycles took place to support the development of person-centred care:

1. The collection and sharing of residents' life histories

2. Weekly team supervision meetings for staff

3. An action learning set for managers in older peoples' services

4. The establishment of a user and carer group

5. Training and audit activities on person-centred care

6. Building links and networks with local organisations

This study describes the processes and outcomes of change working in a collaborative way through action research. At the close of the project, both staff and residents reported higher levels of satisfaction with the service. Repeat baseline audit findings and organisational performance indicators showed improvements in person-centred care, the quality of nursing care provided, the quality of interpersonal interactions and the management of the home. In essence, the quality of care had improved. These interventions had produced positive change.

The importance of this project lies in taking forward the body of knowledge related to more person-centred approaches to nursing care. This is particularly relevant in the light of the

second standard of the NSF for Older People advocating more person-centred approaches to caring for older people (Department of Health, 2001a). The research report contained in the DHealth describes a range of practical interventions that supported the development of person-centred care. Current nursing debates on person-centred care tend to be conceptual and currently offer little in practical ways of developing practice in this arena (Dewing, 2004) and the findings of the research report address this gap in the body of knowledge.

The debates in nursing on person-centred care are now focused upon relationship-centred care drawn from the work of Tresolini and Pew-Fetzer Task Force (1994) in the USA and promoted in the UK by Mike Nolan and colleagues drawing upon the 'six senses' framework (Nolan et al., 2004). In essence, the senses framework and relationship-centred care emphasis the mutuality and independence of experience between the carer and the cared for and the importance of relationships across healthcare systems. These ideas of relationship-centred care offered a helpful framework in this project and were synergistic with my style of working and approach to organisational change based upon the 'Tavistock approach' developed in stage one. This approach is a blend of systems theory and psychoanalysis with psychotherapeutic methods applied to organisational development and action research. The appreciation of the process of projective identification as described by Klein (1975) and Moylan's (1994) description of emotional 'contagion' helped me to better understand the emotional connections and mutuality of experience in this challenging care environment. The lesson drawn from this project is that the 'Tavistock approach', and in particular appreciating projective identification as a process, is a working model that supports more 'relationship-centred' ways of working in practice. The addition of the process of projective identification drawing on psychotherapeutic practices is a new dimension to current professional debates in nursing about relationship-centred care.

1.2 Stage three of my research development - Preparing for doctoral submission (2004)

This final stage of development reflects 'time out' from supporting change in clinical practice. This stage involved a thorough engagement with the literature, provided time to develop writing skills and an opportunity to consolidate ideas.

The literature review in this doctorate examines the concept of person-centred care and the evidence to support the application of this approach in clinical practice for older people. The rationale for the literature review relates to the practice focus of the action research project described in stage two, standing alongside the national standard of person-centred care to be met across the United Kingdom in the next ten years contained within the NSF for Older People (Department of Health, 2001a). The aim of the person-centred care standard is:

> "To ensure people are treated as individuals and they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries."(Department of Health, 2001a: 8)

The NSF for Older People is clearly based upon better customer care through customer consultation and involvement. Williams and Grant (1998) argue that consumerism underpins the policy rhetoric of being person-centred. This ideology involves 'getting close' to the customer to best determine service provision, ensuring the patient and not the healthcare provider is at the centre of care. The consumerist leaning of the person-centred standard is illustrated in the usage of policy language such as the timely delivery of *'packages'* of care (Department of Health, 2001a). Nolan (2001) and Nolan et al (2004) argue that the values underpinning this policy are overly individualistic, consumer orientated and may not best meet the needs of older people. The literature review identifies influences drawn from the existential and humanistic traditions and professionalisation agendas within nursing as being important conceptual components of person-centred care. These latter influences draw upon the subjective nature of human existence and the therapeutic components of helping relationships. From the literature, I argue that current policy in person-centred care does not address the systemic and subjective nature of relationships, which are integral to this concept.

Undertaking the literature review confirmed that the most extensive research in the application of person-centred approaches in gerontological settings has occurred in the field of dementia care. The work contained in this thesis contributes to expanding the clinical focus of person-centred approaches to more generic long term care settings. In addition,

research evidence on staff development required to support person-centred care appeared particularly sparse and research activities in this thesis have developed practice in this field.

1.3 Conclusion

All the elements contained in this DHealth address the interpersonal nature of nursing practice and my engagement and development in this process. Nursing is about caring for people but all too often becomes a ritualised and depersonalised set of tasks to be 'done' – something of an 'old chestnut' in professional debates (Menzies Lyth, 1988). This research portfolio contributes to developing a sense of humanity in nursing and to building more enriched clinical environments. Current professional rhetoric talks about 'relationship-centred care' but this will only be realised when both staff and patients understand what connects and differentiates their experiences of caring. This doctorate indicates that psychodynamic and systems theory is a useful starting point to engage in such an understanding. Finally, current policy advocates person-centred care (Department of Health, 2001a) and this doctorate reports on local implementation and how to create more positive environments of care.

Case Study

SEEING THINGS DIFFERENTLY: EVALUATING PSYCHODYNAMICALLY INFORMED GROUP SUPERVISION FOR GENERAL HOSPITAL NURSES

2.0 Introduction

This case study explores the development of psychodynamically informed group supervision, for 52 clinical leaders in nursing at a general NHS hospital over four years (beginning of 1997-close of 2000). The mid to late 1990s saw a rapid development of theory, policy, research and practice concerning clinical supervision in nursing (Department of Health, 1993; Kohner, 1994; Faugier & Butterworth, 1994; UKCC, 1996; Johns, 1996; Butterworth et al., 1997; Bishop, 1998). However, psychodynamically informed approaches to clinical supervision have been relatively neglected and comparatively few authors have focused on evaluating this specific approach for general nurses (Jones, 2000; Von Klitzing, 1999; Gilmore, 2001; Ashburner et al., 2004a).

Psychodynamic approaches to clinical supervision are common practice in the supervision of psychotherapists and counsellors (Feltham & Dryden, 1994). In addition, this approach is deemed appropriate for the 'helping professions' e.g. nurses, social workers (Hawkins & Shohet, 1994; Hughes & Pengelly, 1997; Cutcliffe, 2001). This case study explores the issues and tensions in assimilating a psychodynamically informed approach to clinical supervision into nursing. This contributes to a growing body of knowledge on clinical supervision and psychodynamic perspectives in nursing.

Expert opinion on the development of clinical supervision in nursing has stated that despite policy drives and accruing research, clinical supervision remains sparsely implemented and difficult to sustain in practice (Bishop, 2004). This case study describes an NHS acute hospital's approach to clinical supervision sustaining its delivery over four years (1997-2000). Findings may be useful to other NHS organisations struggling to implement and sustain systems of clinical supervision for nurses.

2.1 Aims of the case study

The aims of this case study are as follows:

1. To introduce and evaluate psychodynamically informed group clinical supervision for general nurses in an acute NHS Trust.

2. To assess the assimilation of an approach to clinical supervision developed for psychotherapy practice into general nursing.

3. To illuminate the factors influencing sustainability of clinical supervision.

4. To reflect on the process of organisational change whilst introducing an innovation in practice.

2.2 Clinical supervision as defined in this case study

Definitions of clinical supervision abound but it has been suggested that definitions should be devised locally (Butterworth, 2001). For this case study, clinical supervision was agreed locally with stakeholders to be:

> "A process facilitating learning about professional roles, nursing skills and self understanding. It allows the exploration of tensions between organisational, professional and personal relations to develop understanding in these related areas." (Ashburner, 1998:3)

In many ways the process of clinical supervision within this case study mirrors that described by Bond and Holland (1998) in their practical guide to clinical supervision:

1. Regular protected time for facilitation, in-depth reflection on professional practice.

2. Interaction supported by a supervisor with facilitation skills.

3. Supervision is frequent, ongoing and led by the supervisee's agenda.

4. It is a reflective process that permits supervisees to explore and examine the part that they play in the complexities of events.

5. A life-long learning experience that should continue throughout a practitioner's career.

2.3 The broader context: the sparse implementation of clinical supervision in nursing

This section will set the scene and report on the broader context of clinical supervision in nursing and midwifery, before focusing on the local context of this particular case study. This broader contextual information is largely drawn from the literature but also includes my reflections and opinions on policy guidance and professional rhetoric with consequent difficulties and missed opportunities associated with the development of clinical supervision for nurses.

Policy recommendations for the implementation of clinical supervision first appeared in the early 1990s led by the Chief Nursing Officer (Department of Health, 1993). With such policy endorsement professional interest in clinical supervision blossomed and research and education initiatives increased, resulting in a large growth in the nursing literature on the topic (Cutcliffe, Butterworth, & Proctor, 2001). However, despite this rapid growth in research, the efficacy for clinical supervision in practice is difficult to determine as studies reporting on benefits tend to be fairly small-scale (Gilmore, 2001). There is one notable exception and this is the largest study of clinical supervision undertaken in both England and Scotland involving over 586 nurses at 23 sites (Butterworth et al., 1997). Over 18 months no statistically significant differences were found on burnout, job satisfaction, general health, coping and stress for nurses receiving supervision (as compared with those nurses not receiving clinical supervision). However, the researchers argued that the psychometric tests used were inadequately sensitive for their purpose and the qualitative data collected suggested efficacy of clinical supervision. One critique of this study is that the authors did not adequately control the variable they were measuring i.e. the quality of supervision. The lack of statistical significance may be a reflection of the poor quality of supervision rather than clinical supervision *per se*. The

authors acknowledge that clinical supervision was a new development in nearly all the study sites with wide differences in the training opportunities for the delivery of clinical supervision. Other smaller empirical studies have reported benefits of supervision. Teasdale, Brocklehurst and Thom (2001) in a study of 211 nurses also found no statistical difference in burnout between unsupervised and supervised nurses but did report a statistical significance of nurses coping better when receiving supervision. Bowles and Young (1999) in a study of 201 nurses across a community and mental health NHS Trust reported benefits of clinical supervision across a range of managerial, educative and supportive functions.

Despite the growth in education, research and policy initiatives, clinical supervision has proved difficult to implement in practice and has resulted in sparse opportunities for nurses (Bond & Holland, 1998). For instance, from a stratified random sample of 558 nurses in five NHS trusts only 29% nurses had an identified clinical supervisor (Fowler & Chevannes, 1998). More positive rates of clinical supervision were reported by Teasdale, Brocklehurst & Thom (2001) across the Trent Regional Health Authority: 45% (n = 96) reported receiving clinical supervision whilst 55% (n = 115) relied on their own informal networks. From an extensive review of the UK literature on clinical supervision, Gilmore (2001) identified that access to clinical supervision varied between staff groups and types of units but appeared to be most established in mental health and learning disability nursing and in clinical areas that have a progressive and developmental ethos e.g. Nursing Development Units. In support of Gilmore's (2001) position, a survey of 158 community mental health nurses in Northern Ireland across ten NHS Trusts found 81% (n = 124) received clinical supervision (Kelly, Long, & McKenna, 2001a). Interestingly, these authors found that clinical supervision was largely managerially led with less than 2% of supervisees selecting their supervisor by mutual agreement. Interestingly, from questionnaire data from 273 nurse executives in England and Scotland, Bishop (1998) reported the slowest implementation of clinical supervision in acute care. Lack of time and resources were given as the 'blockers' to the development of clinical supervision. When supervision did occur in acute care settings, only 40% of sessions took place during work time. This worrying finding is indicative of the problems of establishing clinical supervision in busy acute clinical areas frequently experiencing

staff shortages (Bishop, 1998). This does not bode well for sustaining clinical supervision in the long-term within acute services.

Bishop (2004) argues the sparse implementation of clinical supervision can be attributed to a lack of resources and in particular financial investment. However, the literature on clinical supervision indicates that there may be a number of other factors influencing the limited implementation of clinical supervision. These factors include professional ambivalence towards the process, unreflective nursing cultures, missed opportunities in clinical leadership and clinical supervision being part of the NHS clinical governance framework. These will be examined in more detail below.

2.3.1 Professional ambivalence towards clinical supervision: surveillance or emancipation?

A factor behind the sparse implementation of clinical supervision in practice can be attributed to the widely acknowledged contradictory characteristics associated with clinical supervision: surveillance (monitoring, inspection, performance management, and disciplinary procedures) and emancipation (transformation, growth, liberation and development) (Faugier, 1992; Bishop, 1998; Bond & Holland, 1998; Hawkins & Shohet, 1994; Gilbert, 2001). Kelly, Long, & McKenna (2001b) describe this as the bi-polar nature of clinical supervision and it will be argued that this bi-polar characteristic leads to potential confusion about the underlying purpose of clinical supervision resulting in professional ambivalence towards the process.

Surveillance: factors contributing to professional ambivalence

The policy push for the development of clinical supervision in the early 1990's sprang out of the Department of Health's response to the actions of the nurse Beverley Allitt. This hospital tragedy led to an enquiry that found inadequate managerial surveillance of staff, and recommended safer and more accountable supervisory practices (Clothier, MacDonald, & Shaw, 1994). The unfortunate association of clinical supervision with the Allitt case, in which inadequate managerial supervisory systems resulted in death and harm of hospitalised children, is a complex, emotive and difficult situation from which to

launch a practice development initiative. The Allitt case was a terrible failure of professional practice. Clinical supervision was seen as a development to help address this situation and it is my opinion that although widely welcomed by the profession, this backdrop of professional failure may have contributed to an underlying ambivalence towards this process. The fact that recommendations for the development of clinical supervision sprang out of a professional tragedy is a difficult start to any professional development as by implication supervision activities are vicariously associated with professional failure. I believe such a backdrop of concern can engender ambivalence.

Furthermore, the 'sister' system of clinical supervision in midwifery also leans heavily towards surveillance. The long tradition of supervision in midwifery has its origins in the inspection of midwives laid out in Midwives Act of 1902 and 1936 when inspectors became supervisors of midwives (Kirkham, 1995). Current models of midwifery supervision are managerial in nature emphasising standards, accountability, professional misconduct and the legislative framework and are generally linked to disciplinary procedures (Bond & Holland, 1998). This approach is not generally associated with the support and growth of practitioners and Demilew (1995) reported on its controlling and disempowering nature from 32 interviews with independent midwives:

> "All of the midwives powerfully articulated supervision was practised in a controlling, negative and obstructive way. They specifically note that the result was to obstruct their clients from accessing the best quality care. This is a sad indictment." (Demilew, 1995: 40).

Indeed a level of concern was reflected in an annexe to the UKCC Registrar's letter outlining the Council's position statement on clinical supervision

> "The midwifery profession has a statutory system of supervision. Even if the law allowed for a similar development, it is not felt this would be appropriate for nursing and health visiting." (UKCC 1995: 1)

Against this backdrop of concern relating to the Beverly Allitt case and the statutory model of midwifery supervision, it is not surprising that practitioners may have felt ambivalent towards calls for the development of clinical supervision (Bond & Holland,

1998). Finally, the term 'supervision' is generally associated with 'keeping an eye on someone' or 'checking up' and as such has rather a negative image. From a more analytical and theoretical level of post structuralism, Gilbert (2001) argues that clinical supervision is the subtle but pervasive exercise of power and represents a new technology of surveillance and social control. Although Gilbert's Foucauldian perspective is controversial, he argues there are confessional and penitential processes underpinning clinical supervision promulgating a form of professional moral social control. Whilst Gilbert (2001) adopts an unorthodox view of clinical supervision, his perspective may shed light on a possible source of ambivalence towards clinical supervision as a new system of moral social control in nursing.

Emancipation: factors contributing to professional ambivalence?

Many authors herald clinical supervision as an emancipatory process (Faugier, 1992; Johns, 1998; Johns & McCormack, 1998) and it is my opinion that the language of emancipation frequently associated with clinical supervision may put off practitioners. For example, the quotation below is typical of the professional rhetoric in this arena

> "the intent is to produce a liberated practitioner by helping the attainment of self awareness" (Heath & Freshwater, 2000: 1299).

This debate is often influenced by transformational frameworks and typically underpinned by neo-Marxist critical social theory (Bond & Holland, 1998). The aims of such writers are laudable but forcing emancipation into a process *by intent* seems rather antithetical to the process of emancipation itself. In addition, the language and rhetoric used e.g. 'liberated practitioner' can be naïve, rather grandiose and at worst patronising (as typified above by implication that 'un-liberated' practitioners lack self awareness). It could be argued that the language of emancipation in professional discourses may contribute to ambivalence and scepticism towards clinical supervision and have possibly worked against its implementation in practice.

2.3.2 Reflection-on-practice: does nursing culture support this activity?

The second factor emergent from the literature in relation to the sparse implementation of clinical supervision is the lack of a reflective culture within nursing to support learning from practice. Fowler and Chevannes (1998) state that the interplay of reflective practice and clinical supervision is very strong. Some examples are given below

> "guided reflection is at the heart of clinical supervision" (Heath & Freshwater, 2000: 1298)
>
> "Clinical supervision brings practitioners and skilled supervisors together to reflect on practice" (UKCC, 1996: 3)
>
> "the milieu where reflective practice is facilitated is called professional supervision" (Johns, 1993:11)

The work of the educationalist and philosopher Donald Schön is highly influential in debates on reflective practice in nursing (Reed & Proctor, 1992). Schön (1983) first argued for a new epistemology of professional practice away from the confines of positivist technical rationality. The tradition of technical rationality sees clinical practice as the arena in which to apply 'higher' theoretical and scientific principles, but Schön (1987) argues that this inadequately reflects the complexity and uncertainty in the realities of everyday professional decision making. Clarke (2001) calls for nurses to be accountable to a technical-rational knowledge base, but equally for nurses to know the limitations of that knowledge and seek new ways to inform the artistry of practice. Greenwood (1993) states that to correct the wrongs of technical rationality Schön's epistemology of practice places problem solving within the broader context of reflective enquiry or reflective practice. However, critique of reflective practice and clinical supervision in nursing is generally very limited (Greenwood, 1993; Gilbert, 2001). Schön's ideas have been highly influential but there appears to be a professional 'blind spot' in appreciating the pervasive and tenacious nature of technical rationality in a scientific and medically dominated health care system (Tresolini & Pew-Fetzer Task Force, 1994). The embedded nature of technical rationality in healthcare is a major threat to the development of more reflective approaches in nursing and has negatively

influenced the development of clinical supervision in practice. Thus, the sparse implementation of clinical supervision may reflect the hegemony of technical rationality in healthcare practice.

Schön (1987) also argues that the pervasiveness of technical rationality in professional education results in practitioners having to learn and develop reflective skills. However, Atkins & Murphy (1993) believe there is a lack of recognition given to the skills nurses need in order to engage in the process of reflective learning and clinical supervision:

> "There is, implicit in the literature an assumption that certain cognitive and effective skills are necessary to engage in reflection." (Atkins & Murphy, 1993: 1190)

In support of this position Bond and Holland (1998) argue that there are a number of psychological blocks or social defenses against the implementation of reflective practice and clinical supervision. These are linked to the vulnerabilities associated with emotional expression, fears of dependency generated through the supervisory relationship and relating to supervisory 'authority' figures. They argue that all too often nursing culture does not adequately address these fears and concerns thereby failing to support emotional growth and learning. Fowler & Chevannes (1998) make some critical comments concerning the wholesale acceptance of reflection in clinical supervision. This information was based upon questionnaire data from 558 nurses, which found that:

1. Reflective practice may be an alien and unhelpful way of thinking for some practitioners

2. There may be instances when a more directive teaching programme may be more appropriate e.g. learning a technical skill

3. Reflective practice may add more stress and not relieve stress for some professionals

Fowler and Chevannes' concern over the wholesale acceptance of reflective practice in nursing is a rather lone voice amongst the generally enthusiastic calls for its development. However, such concerns need serious consideration when the implementation of clinical

supervision is making poor headway in becoming part of the reality of clinical practice for the majority of nurses.

2.3.3 Leadership development: a missed opportunity to develop clinical supervision

The sparse implementation of clinical supervision may reside with the failure to more clearly link clinical supervision with leadership development in the NHS. In 1999 the Government's nursing and midwifery strategy *Making a Difference* integrated clinical supervision within leadership development and recommended NHS organisations to

> "use clinical supervision and statutory midwifery supervision to help identify, support and develop nurse, midwife and health visitor leaders" (Department of Health, 1999a: 55)

The Labour Government's commitment to improving the NHS, as subsequently laid out in 2000 through *The NHS Plan* (Department of Health, 2000), saw the development of nursing leadership as vital to support change and deliver improvements in quality. However, in *Making a Difference* (Department of Health, 1999a) the links between clinical supervision and leadership development are inadequately explicated thereby missing an opportunity to combine leadership development with effective systems of clinical supervision. This failure in policy represents a missed opportunity possibly contributing to the sparse implementation of clinical supervision.

From a policy perspective Butterworth (2001) argues clinical governance as laid out in *A First Class Service* (Department of Health, 1998) creates a legitimate 'home' for systems of clinical supervision within the NHS and he states

> "Participating in clinical supervision in an active way is a clear demonstration of an individual exercising his or her responsibility under clinical governance." (Butterworth, 2001: 320).

Whilst Butterworth's alignment of clinical supervision with clinical governance is well argued there are some flaws in his proposal. If clinical governance is the 'home' for clinical supervision by implication this means it was somehow 'homeless' before the NHS quality framework was established in 1998. This is not adequately explored in his explanation of the links between clinical governance and clinical supervision. Earlier it was argued that professional ambivalence was sustained through the bi-polar nature of clinical supervision and in particular the problematic characteristic of surveillance. Clinical governance quite appropriately has characteristics of monitoring and accountability as the following quotations show:

> "Clinical governance has an important role to play in restoring public confidence in the NHS" (Department of Health, 1998: 34)

> "a systematic approach to monitoring and developing clinical standards" (Department of Health, 1998: 39)

Drawing on earlier arguments, it could be that the alignment of clinical supervision with clinical governance by Butterworth (2001) sustains professional ambivalence due to the surveillance and monitoring inherently part of clinical governance. This may work against the local implementation of clinical supervision in practice. Indeed, a better 'location' may be the closer alignment of clinical supervision with NHS leadership initiatives as these are developmental in orientation and not integrated to any types of standards monitoring or surveillance of practice (Cunningham & Kitson, 2000). Unfortunately as discussed earlier, this appears to have been a missed opportunity.

2.3.4 Concluding remarks on the broader context of clinical supervision

The literature indicates difficulties in the implementation of clinical supervision with only 29-45% of nurses receiving clinical supervision in England across a range of NHS Trusts, although much higher rates (81%) were reported for community mental health nurses in Northern Ireland (Fowler & Chevannes, 1998; Teasdale, Brocklehurst, & Thom 2001; Kelly, Long &McKenna, 2001a). There is recognition that inadequate funding may be a key factor in the sparse implementation of clinical supervision for nurses (Bishop, 2004).

However, in this section it has been argued there are other factors contributing to this situation. These include professional ambivalence towards clinical supervision due to its bi-polar nature (surveillance versus emancipation), an unreflective professional culture, missed opportunities associated with clinical leadership developments in nursing and concerns over clinical governance as the most appropriate 'home' for clinical supervision. These factors indicate some of the barriers to establishing clinical supervision and provide a backdrop as to why this professional activity seems to struggle to embed and sustain nurses in clinical practice. This case study provides an approach to clinical supervision that had to negotiate these barriers and seek to build the body of professional knowledge as to how to sustain and embed clinical supervision in everyday nursing practice.

2.4 Local context of the case study

The study took place from 1997-2001 in an inner city general hospital with approximately 450 beds. The hospital was located in a poor borough (rated 17th out of 354 boroughs in England and Wales) with correspondingly high mortality and morbidity rates associated with economic and social deprivation. The hospital opened in 1985 and achieved NHS Trust status in 1995. From the mid 1990s a £35 million capital build programme took place expanding the physical resources of hospital. Associated with this investment, the hospital's reputation developed as an efficient and well managed NHS Trust. In 2001 the hospital was awarded three star status in relation to NHS performance indicators as determined by the Commission for Health Improvement.

The rationale for developing clinical supervision for nurses was based on a range of factors. An important factor was guidance and directives from policy makers (Department of Health, 1993; UKCC, 1996) promoting the development of clinical supervision, although no recommendations were given concerning the model or approach. There was an acute local nursing shortage with high vacancy rates (15-28% across local NHS Trusts[1]) and subsequent high usage of agency nursing staff. It was recognised by managers that the hospital nursing staff were experiencing high levels of

[1] Supplied by local confederation workforce data

stress. In light of these factors, a consultation exercise about the implementation of clinical supervision with all F, G, H, and I grades and senior nurses (n = 140) took place. This involved sending out a questionnaire and invitation to the staff to attend a 1.5 hour consultation meeting. Four meetings took place. The consultation revealed that whilst there was an interest from these staff in receiving clinical supervision, there were concerns about having the necessary facilitative skills or time and resources necessary to put clinical supervision into practice. Participants indicated that external experienced supervisors would be most helpful given clinical pressures and staff shortages. As a result of the consultation external clinical supervisors were recruited to provide clinical supervision. Due to the long-standing tradition of clinical supervision in counselling and psychotherapy, supervisors were sought with experience in these fields.

I took up post in 1996 as a senior nurse for education at the hospital. Part of the remit of this role was the development of clinical supervision for nurses. At this time I was undertaking a Master's degree in organisational consultancy using psychoanalytic approaches and was interested in developing learning in this arena. This course provided a psychoanalytic approach to organisational change and development. The consultative skills gained on this programme were incorporated into the leadership and management of this clinical supervision initiative. However, it was recognised that a psychoanalytic orientation to clinical supervision may not be suitable for nurses and there was an element of risk in adopting an approach utilised in psychotherapy. Indeed Feltham & Dryden (1994) argue that supervisory systems can only be effective in supporting learning if there is a reasonable congruency with the supervisees' own theoretical orientation. The need to explore and evaluate this new initiative was thus thought to be paramount within the Trust.

2.5 The initiative

The local education consortium funded the first year of the initiative and allocated £22, 000. The consortium funding enabled up to 56 staff members (F, G, H and I grade) to receive approximately 40 hours of clinical supervision per year (meeting on average every two weeks for 1.5 hours). This level of supervision input was consistent with the

psychodynamic approach but is more intensive than the norm (4-6 weekly meeting) in general nursing (Bowles & Young, 1999). In addition, funding also supported the provision of supervision for the supervisors on ten occasions (for two hours) in the first year.

All nursing staff (F grade and above) were invited (n = 140) to participate with 40 (29%) of those invited agreeing to join a supervision group. Interestingly, this local take up rate of 29% for clinical supervision is identical to the percentage of nurses surveyed (n = 558) by Fowler and Chevannes (1998) who were able to identify a clinical supervisor. This indicates a local congruency with rates of supervision reported elsewhere. Over the four years of this study the percentage of nurses receiving clinical supervision remained more or less constant. Ongoing recruitment to the groups was via the senior nurse managing the project with invitations sent to new staff members or those internally promoted to F grade posts and above. The group membership consisted of peers (team leaders and service leaders) with no line managers present. There was a maximum group size of eight members. By the end of 2000 there were five staff supervision groups plus the group for the supervisors with an annual cost of £2,000 per group (the payment of a supervisor for 40 hours per year). A contract was devised for each supervisory group outlining issues of accountability, confidentiality, review processes, and group gate keeping.

The group supervisors (n = 11, over 4 years) had various psychodynamic trainings e.g. from the Institute of Group Analysis and Tavistock Clinic. Supervisors were either nurses (n = 7) or social workers (n = 4) with extensive experience of clinical supervision in health and social care settings. Although all of the supervisors had experience in working in a psychodynamically informed way, their styles of working with staff were not homogeneous. For example, some groups were more formally structured whereby a supervisee would discuss an issue for the duration of the session whilst other groups were facilitated in a more spontaneous way whereby issues and dilemmas would emerge from a general discussion with all group members. However, all the groups had a supervision contract with associated ground rules. The position of the supervisors as outsiders afforded them an added advantage of 'naivety' to question the cultural norms of nursing. Such questioning, through appreciation of difference is thought to be a good mechanism to support learning (Campbell, 2000). Supervision for the supervisors was provided by a

member of a psychotherapy department with a long tradition of applying the Tavistock approach to human service organisations (Obholzer & Zagier Roberts, 1994). The group supervisors met together on ten occasions per year for 1.5 hours to be supervised as a group to share their experiences and consider their practice.

A project steering group was established, this included representation from supervisees from each group, supervisors and senior nurse managers. The project management of clinical supervision activities lay with myself as a senior nurse from February 1997 to January 2000. A newly appointed assistant director of nursing took over the management and leadership of the project from early 2000 but was in post for only 12 months. A new assistant director of nursing then managed the project from early 2001. The steering group met bi-monthly for the period of the study and was the formal arena for decision making, consultation and feedback on the development of the initiative. There was active representation from supervisees and supervisors. These representatives presented issues derived from their group's agenda. All efforts were made to make these meetings facilitative, responsive and collaborative in style.

The locally agreed purpose for the supervision groups was to foster an exploration of the experiences of nursing work in order to promote learning about professional roles, nursing skills and self awareness. The groups were encouraged to explore the tensions between organisational, professional and personal relations to develop understanding in these related areas.

2.6 Defining the psychodynamic perspective informing this case study

The approach informing this case study can be described loosely as the 'Tavistock approach' in which unconscious phenomena are linked to systems theory in order to understand the complex interplay between people, organisations and their environments (Lawrence, 1999). Gould (2001) identifies two main tenets to the approach: the structural systems of organisations and psychoanalytic theory.

The approach is based upon the idea that the structural systems in which people work impact on behaviour. This includes the division of labour, levels of authority, the nature

of the work, the task of the organisation, and transactions across boundaries. These affect individuals in significant psychological ways. Exploring and understanding these influences can positively support organisational understanding and learning (Gould, 2001).

The other main tenet is that psychoanalytic theory provides a range of mental constructs (e.g. transference, resistance, splitting, projection and social defense systems) through which the emotional life of groups and individuals can be understood. In particular, Kleinian psychoanalytic theory is influential in this approach (Halton, 1994; Gould, 2001). The process of working through issues, integral to a 'classic' therapeutic relationship, is applied to the collective social defenses (Menzies Lyth, 1988). This may create opportunities for learning and development. Awareness and insight through acknowledging and understanding difficult feelings is a hallmark of good professional practice (Hawkins & Shohet, 1994). Hirschhorn (1997) argues that feelings of anxiety are the fundamental roots of alienated relationships at work and these feelings are related to the primary task of the organisation. In order to manage these feelings a work group deploys a set of social defenses (Menzies Lyth, 1988) and by using these social defenses people retreat from role, task, and organisational boundaries. Group development takes place when group members stop scapegoating others, when they cease using each other or outsiders to manage their shared anxiety. In doing so they become close to confronting their primary task and reach their most effective performance. The psychological process of reparation helps limit the level of social irrationality and provides a strong basis for group development (Hirschhorn, 1997).

The 'Tavistock approach' is criticised by the industrial sociologist Richard Brown (1992) who argues the approach maintains the status quo and does not challenge systems of oppression and power in organisations. This is certainly a critique one could wage against the work of Menzies Lyth (1988) who worked at the Tavistock Institute on her examination of hospital nursing in the late 1950s. No mention is made in this seminal psychoanalytical work of the power relations between nursing and medicine and the issues relating to gender of an all female professional group. The links between the psychological (and the social defense mechanisms) and the political and social is one that is challenging to the Tavistock perspective. Brown (1992) argues that the Tavistock

approach frequently pays little attention to the wider society, in which all too often there is an uncritical acceptance of the economic order. Further critique is made concerning the universal terms of psychoanalysis in which the assumptions of basic human needs are unproven. Finally, the conceptualisation of an enterprise as a unified system with a clearly identifiable purpose (primary task) and with activities and relationships appropriately structured to complete this task is overly simplistic and denies the complexity of organisational life (Brown, 1992).

Whilst the criticisms above are pertinent and reflect weaknesses with the approach, this needs to be weighed against the usefulness of the Tavistock approach in practice. The 'Tavistock' approach to organisational change through the re-alignment of social defences is a helpful one when introducing an experiential intervention such as clinical supervision. Brown (1992) argues that this approach is a useful starting point for a researcher or consultant wishing to make a change within an organisation.

2.7 Methodological approach

Action research was used to introduce and develop the initiative described in this case study. Meyer (1993) describes this as part of a new paradigm of research born out of the limitations and hegemony of technical rationality in professional practice (Schön, 1987). This is also congruent with the psychodynamic approach, which is based upon learning from experience and in particular from the emotions of the workplace (Gould, 2001).

The action research approach adopted in this case study is best described by Winter and Munn-Giddings (2001) as 'responsive evaluation'. The central tenet of this approach is an illuminative process, which Winter and Munn-Giddings (2001) believe is well suited to the introduction of innovatory programmes. The purpose of responsive evaluation is to see how the innovation is influenced by institutional factors, to describe what those directly involved have to say about the innovation and to discover what it is like for those who are participating. Responsive evaluation seeks to address and illuminate a complex array of questions. This is based upon the premise that evaluation evidence can be rarely scientifically controlled to reflect the complexity of actual situations. Responsive evaluation is undertaken in social situations and Winter and Munn-Giddings (2001) argue

that competing interest groups make this process inherently political. An illuminative model of action research is responsive to the different interest groups and individuals in both trying to clarify effectively and to describe the issues and conflicts across groups.

Consultation and feedback with staff helped shape the development of this initiative. Feedback and guidance on the initiative's development and evaluation were sought via staff and supervisor representation on the steering group. Annual reports from each group on the experience of supervisees were submitted to myself as project leader. The annual group reports were written by the supervisors in consultation with group members and all information was presented anonymously with the permission of participants. This process gave participants an opportunity to reflect on their experience of supervision over the previous 12 months. These annual reports from group members were useful to me in helping lead the development of this initiative e.g. giving the supervision groups greater control over the arrival of new group members.

Three evaluations on the project's development were circulated to all the supervisees and supervisors (and with subsequent approval of participants circulated to senior managers) from 1997-2000. These reports related to issues and dilemmas in the establishment of this approach to supervision and evaluations of the process by participants. Overall feedback on these reports from participants to myself as project leader was via the steering group through the supervision group representatives. This established a democratic and participative mode of managing and developing the initiative.

2.8 Data collection

The data collection reported in this case study relates to research activities during the latter part of the project and reflects the findings reported in the final and most substantive organisational report written by myself as project leader. This allowed for an evaluation of the project established for four years and a review of issues relating to sustainability. Data collection involved descriptive statistical information concerning sickness rates and turnover of staff leaving the hospital in order to assess any potential impact of clinical supervision in these areas Qualitative data in the form of 24 tape-recorded semi structured interviews was collected by the project leader from November

2000 to January 2001. The purpose of the interviews was an in depth exploration of the experience of clinical supervision by both supervisees and supervisors. The range of questions included the purpose and value ascribed to supervision, areas of learning (if any), any difficulties encountered (if any), project management issues and thoughts for future development (see Appendix One on page 47 for interview schedule).

This in-depth data collection and evaluation was triggered by the participants' concern over changes in management of the project. During 2000 an assistant director of nursing led the project for only 12 months creating instability and anxiety about the project's future. Participants wanted to give a clear picture of the issues in order to provide a sound basis for future developments and decision making.

Clear guidance on the voluntary nature of participation in the study was given to all research participants to maximise confidentiality and anonymity of participants. This was in accordance with local research ethics committee approval. Seventeen interviews took place with supervisees representing 57% of total clinical supervision group membership (n = 30). All supervisors (n = 7) involved with the study over the 3 month interview period were interviewed.

The interviews were transcribed verbatim and analysis of the interview data involved re-reading of transcripts and building common themes (Coffey & Atkinson, 1996). However, Winter and Munn-Giddings (2001) in the analysis of data in action research state the process is about learning and implementing change rather than constructing an interpretation as in other forms of research. They warn that elaborate time consuming data analysis should not deflect from the action orientation of the method. This evaluation took place at a time of leadership change and was responsive to participants' requests. The report written was circulated to all participants. Comment and feedback was firstly via the steering group and then, with their approval circulated to senior nursing managers. In addition, data collected provided the new manager of this clinical supervision initiative with an in depth analysis of the project and secured the ongoing funding for this initiative (see further discussion on page 40).

2.9 Findings

Descriptive statistical data concerning nursing staff sickness and turnover through the organisation were used to assess crudely the impact of the initiative. The process issues of the initiative were identified through semi-structured interviews and will be presented as nine themes.

2.9.1 Impact on sickness rates

Hospital statistics showed that staff members who had been in supervision for 12 months and over had lower sickness rates (1.1%) than non-supervised staff of similar grades (4.1%). This was almost a quarter of the total average rate of sickness for nurses and midwives in the organisation of the same grades. There cannot be any claims of causality, but none the less the finding is interesting. The percentage of lost time due to sickness was also lower than every other nursing grade across the organisation. Data collected concerning sickness was provided by the workforce planning department and further analysis of statistical significance was not possible because of limited human resources.

It raises the question as to why those in supervision for a year or more were seemingly less ill? Indeed, the voluntary nature of this initiative may have attracted motivated staff possibly more satisfied at work. A longitudinal analysis of sickness data pre supervision and subsequent to receiving supervision is a recommendation for future evaluation.

2.9.2 Impact on staff turnover

From January 1998 to January 2001 a total of 52 nurses ranging from F, G, H and I grades received clinical supervision. From this total of 52 nurses, 11 group members left the hospital and 11 staff members remained in the organisation but no longer accessed supervision. The staff leavers rate for those receiving supervision is 21% (n = 11). This is consistent with hospital annual staff turnover rates of 20% – 24% (from September 1998 to September 2000). Clinical supervision did not appear to contribute in reducing staff turnover.

2.9.3 Process issues emergent through interview findings

The qualitative analysis of the transcribed tapes (n=24) of both supervisors (n= 7) and supervisees (n=17) revealed nine themes. The themes describe both the benefits and difficulties of this initiative. The theoretical perspectives of this psychodynamic approach inform the analysis and reporting of the findings.

The reported benefits for participants (themes one to six) lay in the acknowledgement of feelings, building confidence, reducing isolation in role, working through a crisis, better relationships within the organisation and valuing the role of the external supervisor. However, identified difficulties of the initiative (themes seven to nine) were fragmented attendance, the fears of getting started in a group and difficulties in opening up.

2.9.3.1 Acknowledging feelings

Interview data from both supervisees and supervisors acknowledged clinical supervision sessions as a place where emotions could be explored in relation to clinical practice. A supervisee stated:

> "You know I think it's helped me learn to value my feelings about things.... but also to try and use them in a constructive way,....to accept that, you know I'm not always right and that there are different solutions to problems.... I suppose, you know there are different ways of approaching it" (supervisee 3.9 p.6)

This exploration of feelings was generally seen in a positive and supportive light. However, the supervisors identified that this was time consuming, extremely demanding and seemed a largely alien process for most nurses, requiring a degree of risk taking on the behalf of group members. It appeared to be a constant 'uphill' struggle to keep feelings and emotions integral to supervision. Equally the supervisors reported some dilemmas in their approach particularly over the extent and level of psychoanalytic interpretation of a situation.

> "But I've had real difficulty in making judgements about how to use the psychoanalytic bit within the group, and how much to be more practical and down to earth with them in a way." (supervisor H, p.2)

However, it is through the acknowledgement of feelings and emotions that experiential learning can take place (Brockbank & McGill, 1998). There was recognition that the working with feelings and emotions was integral to this approach.

> "I think *(the supervisor)* is trying to get us to express our feelings about the everyday working environment and the problems we encounter, rather than blocking them up. I think she kind of guides it as well to go in certain directions.....I think she also encourages us to think about the things we do at work. And the way we respond to people, our patients, our staff our colleagues." (supervisee 2.15 p.6)

To be able to engage and analyse feelings and emotions requires accepting vulnerability in an environment of support and trust. In psychodynamic terms, the role of the clinical supervisor in the group is as a psychological 'container' of emotions. The 'containment' of emotional experience develops thinking, understanding and healthy development (Bion, 1961; Bion, 1967). However, as one nurse recognised in a 'nursing culture of coping' engaging with feelings is often denied and opportunities for learning and development are lost.

> "It sort of throws out my trained views and sort of working experience, you've basically had to cope and you've had to be in a difficult situation where you've obviously been unable to cope properly as a manager - so you develop this protective shell. And I think for me that is one thing and it's hard for anybody or even myself to go beyond that protective shell and open up to somebody, its tough." (supervisee 8.1 p.7)

The supervisors were acutely aware of the risks associated with working with supervisee vulnerabilities and the personal risks people took in presenting issues.

> "I mean the issue might be that there's a difficulty in, I suppose being self-reflective in a way. It perhaps compromises someone's defensive strategies that have been developed in a way of coping with some of these things." (supervisor K. p.7)

The 'protective shell' described by the nurse may represent the system of social defences described by Menzies Lyth (1988). These are described as the structure, culture and mode of functioning in a social organisation. From a systems psychodynamic perspective these defences are seen as either impeding or facilitating new learning. Here, the nurse insightfully comments on her professional socialisation and how it may limit the capacities 'for opening up' and of learning in new ways. This recognition as to the limits of professional culture was indeed new learning and suggests that a psychodynamic approach did offer new insights into professional practice. However, learning this way appeared hard won.

2.9.3.2 Building confidence

A clearly stated benefit from the supervisory process related to the nurses feeling more confident in their roles. This is illuminated below:

> "I had a particular problem with a member of staff, where I actually felt as if I was stepping back and not dealing with the situation because I was too scared to deal with it...and I bought this situation into supervision and you know they all said stand up for yourself and it gave me the confidence to actually deal with the situation." (supervisee 2.13 p.3)

Here the nurse found authority and power in her role through group clinical supervision; she recognised her avoidance of a difficult issue and successfully used the group to address the situation. From a psychodynamic perspective (Obholzer, 1994) describes authority within organisations as the right to make decisions, which are binding on others. Authority is from 'above', derived from one's role in a system, from 'below' through those who sanction part of their authority to others and finally from 'within' in relation to past authority figures e.g. parental figures held 'in the mind' (Obholzer, 1994). It is inappropriate to explore the supervisee's experience of past authority figures in clinical supervision as this is not the given purpose of the groups. However, supervisors mindful of the rich mix between the conscious and unconscious psychological worlds can

help to understand both rational and less rational organisational struggles and behaviours. In addition, as evident from the feedback from the supervisee quoted above, working with peers in a group can create opportunities for working through issues of power and authority in role.

2.9.3.3 Reducing isolation in role

It seems that many clinical leaders worked in isolation with few real opportunities to share and learn together. The sense of isolation in nursing roles can compound feelings of personal inadequacy and failure further contributing to low morale (Meadows & Levenson, 2000). The opportunities to share issues allowed the clinical leaders to feel less burdened with the responsibility they carry in role. Addressing issues of isolation is well illustrated by a group member:

> "ward work can be quite insular and you just get tied up with what's going on in your ward.... and you don't know the other G grades on the wards that well, ...so to actually have to listen to other wards and how they are going through the same sort of thing, ...you know it's not just us getting all the complaints from the angry relatives, ...it's other wards as well because sometimes you feel you are getting them all" (supervisee 9.4. p.3)

Staff described how they took issues home to family and friends. Clinical supervision seemed to play a role in reducing staff anxieties, which may spill over to home and family life. Three nurses describe how supervision stopped them 'taking work problems home' and an example is given below.

> "To be able to go somewhere and say oh God, it makes me so angry, I wanted to hit him ....because I could take it home, I could talk to my partner about it, ...but it wasn't the same, because he is not there, he doesn't know you know. So to be able to share that with other nurses was important." (supervisee 3.5 p.4)

Facing negative feelings is all the more challenging in a profession committed to caring. Cotter (2001) describes an important part of analytical psychology is 'grasping the shadow', working with feelings that are repressed because individuals feel that they are not acceptable. Here the nurse describes how feelings that were only shared at home (in

the shadow of work) were brought into the workplace through clinical supervision. The interface between individual experience and the group can promote a better understanding of the reality of a situation; as one group member stated "you realise you're only human" (supervisee 2.14 p.13).

2.9.3.4 Working through a crisis

Group members described reaching a crisis point in which they were seriously considering leaving their job. They considered clinical supervision played a crucial part in working through an issue and helping them to re-consider their options.

> "I was very, very unhappy...and then clinical supervision made me work out a way of dealing with it, coping with the stresses of it and working through it." (supervisee 2.1 p.7)

Clinical supervision offered a place to deal with uncertainties and 'not knowing'. Psychodynamic practice applied to organisational life can shift the 'rushed'/immediate knowingness (an unreflective position) of a situation towards a deeper level of understanding (Dartington, 1994; Cardona, 1994). There is little doubt that this theme of working through a crisis was closely linked to a reduced sense of isolation in role. From the interview data all too often the clinical leaders appeared to have extremely limited networks of support whilst working in tough and demanding situations. This often drove participants to consider leaving the organisation:

> "I think it is possible that without supervision I may have left at that point..." (supervisee 8.4 p.7)

> "I was just about to hand in my notice and I went to the meeting and talked about it and you know, well I found a slightly different approach.....it helped me talk about my career." (supervisee 11.4 p.8)

Although statistical data did not show any reduced turnover rates for those receiving supervision, interview data seemed to indicate that clinical supervision helped staff in working through a crisis when participants frequently considered leaving the organisation.

Whilst clinical supervision may not impact staff turnover, interview data suggests that it may have raised staff morale and reduced stress. As one supervisor stated:

> "And if they can take a slightly more objective look at what they can and can't do, it helps to reduce the stress levels. I mean I see that as a very important element, because the whole time every single member of staff is squeezed. There aren't enough resources. There is not enough time." (supervisor I, p.15)

2.9.3.5 Better relationships within the organisation

This approach to clinical supervision supported clinical leaders in improving their relationships particularly with senior managers:

> "I was having issues with a senior manager...and I felt quite angry about the way a couple of things had happened, and I spoke about it in the group and as a result I felt a lot better in myself." (supervisee 9.4, p.3)

Additionally, better networks of support and collegial relationships were established:

> "We meet outside the group, just to have a chat, find out what's happening....and its part of being valued." (supervisee 2.1 p.8)

A psychodynamic approach to clinical supervision is about exploring and understanding relationships. Participants most frequently reported benefits of clinical supervision in dealing with their colleagues rather than patients *per se*. Yegdich (1999) might argue that this collegial focus within the supervision groups is a psychological defence against understanding the patient's experience. Indeed, this may be a cautionary note and warrants consideration. However, the role function of the participants was managing and leading staff teams, and not unsurprisingly staff relations reportedly took up a high proportion of discussion time.

2.9.3.6 Role of the external clinical supervisor

Staff interviewed were all positive about the role of the external supervisor. It was seen as a strength to be able to discuss issues with a person external to the organisation. The clinical leaders felt that the supervisors were impartial, listened to their issues and offered

fresh perspectives. Overall, staff wanted the model extended to other junior staff groups. One of the participants said:

> "I think the feeling I get from the supervisor is that she is there to sort of listen to us and I think quite subtly um...what shall I say.... maybe get make us think about things in a different way.....from a different angle that you might not have thought about... but I think it is quite subtle the way she does it, because she doesn't say have you thought about doing it this way she makes you come round to that yourself." (supervisee 9.4 p.4)

Both supervisors and a small number of participants voiced their concern over the turnover of supervisors in the period prior to the evaluation interviews. The supervisors contract requested a commitment to the group for a minimum of one year. Supervisors felt this commitment was too short for this type of developmental work. Any new supervisors should be committed to a group for a period of at least two years.

Supervisees generally perceived the supervisors as extremely skilful in how they worked and valued their reliable attendance at sessions. There was clear evidence that the sustainability of clinical supervision was perceived by all participants to be attributable to the role of the external supervisors. However, only two supervisees interviewed felt they would be interested in acting as group facilitators for junior staff members. On the whole staff interviewed felt too pressurised in their roles to take on extra activities. As a future development, the nurses interviewed did not welcome adopting a 'cascade' model of supervision in which group members would supervise more junior staff.

Supervisors and supervisees voiced concerns over the initiative being at risk of becoming isolated and disconnected from NHS Trust strategic developments and therefore recommendations were made to align this initiative more closely with clinical leadership developments taking place within the hospital.

2.9.3.7 Fragmented attendance

Data collected by supervisors from 431 sessions (1 to 1.5 hours in duration) showed average attendance of staff at the sessions was 58%, with a variation of 49% - 70% across groups. With the exception of one supervision group, the sessions commenced in the

afternoon during the period of shift overlap. A hospital nursing service works constantly round the clock, every day of the year. The system runs on nurses being both 'on' and 'off' duty. Absence of a team member is an inherent part of working life but both supervisors and supervisees reported frustration at the levels of absence while acknowledging that shift patterns and patient emergencies were part of hospital life. All the supervisors commented on absences in the groups as being in part a reflection of hospital culture and the challenges this created:

> H: "its to what extent do you deal with you know the personal bit, which is people are not coming because they're ambivalent? To what extent do you deal with the practical bit, which is people are absent because it is really difficult to get off the ward because there are no staff"
>
> C.A: "Yep"
>
> H: "And to what extent do you deal with the macro bit which is, you know, that notion that absences in this group don't really matter because your absence in the hospital doesn't matter and if you don't come to work you are replaced. An agency person comes. So to what extent is what goes on in the group in terms of absence, a reflection of the way which absence is treated within the hospital." (supervisor H, p.3)

A pattern of 'exit by non-attendance' was a feature of the groups: "We've had problems in our group with people who have not attended for a long while" (supervisee 8.4, p.10). It was largely unhelpful and perceived as destructive of the group processes. However, the reality of low staffing numbers and high nursing vacancy rates over the study period was a problem. This situation is illustrated through one supervisee saying:

> "I think people are committed to coming, but if you've only got one other trained member of staff that is coming onto the ward and you're the second person and there is no one coming until 3.30, you can't justify leaving the ward. I mean it hasn't happened to me very often, but it has been on occasions and you know its difficult, you have to sort of toss a coin and think well do I risk it this time and assess the situation." (supervisee 3.5 p.5)

Interestingly, no clinical leaders reported asking senior managers to help 'cover' the ward in times of staffing shortages to allow them to attend sessions. The supervisors commented that a culture of coping seemed pervasive.

2.9.3.8 Difficulties in getting going in the group

It seems that entry into a group is stressful with staff reporting feeling uncomfortable and as if they were wasting their time. One group member stated that she did not like it at the start and was going to leave (supervisee 8.3 p.1). Additionally, it takes persistence and time for members to feel part of a group and for one participant it took five months to settle in (supervisee 8.1 p.1). Staff described initial struggles to see the value and benefits of attending. The alien nature of experiential learning and working in groups was described by one member at her first meeting as like being on the Gerry Springer television confessional programme. In a rather less colourful way, a group member said "it was bit tense to begin with, before you got to know the group" (supervisee 2.12 p. 3). Experiential groups of this nature are alien and unfamiliar in nursing. It took resilience and persistence to get going and feel comfortable in the group and assimilate the differences of a new way of working:

> "Because obviously I heard about clinical supervision, but I've never been in a position or area where it is in force, so I went there quite blind really, I didn't know what to expect and... um, I think it was my third meeting and I did a presentation and I think that was the beginning of it for me because the first two weeks I felt I was wasting my time, I hadn't come to grips with why I was there or what to expect, so after I made a presentation, everything seems to fall into place." (supervisee 2.11 p.1)

For some members the first few sessions proved too negative and they left the group. The nurse below describes her negative experience:

> "I only attended four sessions ...and the group I was in was quite small and I felt there wasn't a lot of dynamism in the group and personally I didn't gain very much from going and I wasn't upset to be missing it." (supervisee 9.5 p.1)

2.9.3.9 Difficulties in opening up

Clinical supervision was recognised as involving personal disclosure, and as one member said she had "not got enough out of it because I haven't opened up" (supervisee 8.1 p.12). Another supervisee (8.3 p.5) said it required "exposing vulnerability and being open to not look so good". Until this fear was confronted, the value ascribed to supervision appeared marginal.

Particular concerns over vulnerability and personal conflict between members (existing before entry to the group) were described as extremely difficult to handle by three group members and two supervisors. One participant described the response (through non attendance) to conflict in the group:

> "There was less and less attendance from the group members as well, including myself – I haven't really been perfect – I didn't attend all the sessions myself ....I lost interest in the whole programme completely." (supervisee 2.16 p.2)

Certainly, the supervisors reported that areas of conflict between members seemed to remain a largely silent subject and appeared to be handled through poor attendance or exit from the groups.

2.9.4 Summary of the nine themes

In a profession dedicated to caring for others, taking time out from busy roles to reflect on practice was challenging. From a cultural perspective, this may go against the grain and challenge the norms. However, the majority of those interviewed were able to use the process well and described benefits to their professional practice. From this initiative there was little interest from participants in becoming supervisors and facilitating junior staff groups. Overall the psychodynamic approach to supervision did seem to support nurses in their role and the external supervisors were particularly valued.

2.10 Outcomes of change subsequent to the evaluation

The findings reported above were disseminated in a written report to all supervisees and supervisors. Two steering group meetings were utilised to discuss feedback from group members and supervisors and agreement secured for the wider circulation of the report. A presentation of findings was made locally to the Nursing Strategy Group. In the light of this report, ongoing funding was secured for this initiative ensuring the sustainability of this approach at a time of change in its leadership. A 'cascade' model of supervision was not introduced despite managerial enthusiasm. Interestingly, this approach to clinical supervision is still in use three years after this evaluation.

Greater links were made with the clinical leadership developments taking place in the NHS Trust, in particular identifying the synergy between clinical supervision and action learning sets integral to the Trust's clinical leadership programmes. Clinical supervision was seen as both a precursor to support practitioners to be able to utilise action learning effectively and to provide practitioners with ongoing development on completion of leadership programmes.

2.11 Reflections on researcher and manager roles

I was concurrently involved in this project as both an NHS manager and as an action researcher. At the commencement of this work there was managerial pressure to 'get the initiative off the ground' and insufficient time allowed for an exploratory approach. Although staff were consulted, a particular approach to clinical supervision was adopted quickly. However, on reflection perhaps a range of different clinical supervision approaches/models could have been utilised offering a choice of styles and approaches to participants. This would have allowed an internal comparison with different systems of supervision, but this would have been more complex and demanding to establish. At this crucial time I was new in post and involved in building a team and establishing a new educational role in the organisation. The managerial priority was keeping the initiative simple in design and containable in terms of time and resources. Hence, 'a one size fits all' approach was adopted.

One question that remains unanswered in this evaluation is the extent to which this way of working *per se* created the conditions for sustaining clinical supervision over time. Consultation with nurses in this case study indicated that whilst they welcomed the opportunity to receive clinical supervision, concerns existed over high workload pressures, severe recruitment difficulties, the lack of facilitation skills and a nursing culture fearful of 'opening the lid' on emotions. The methodological approach adopted in this case study demanded this feedback from participants be taken seriously. As a result, the model of external supervision was adopted. This approach was radically different to the strategies in other local NHS Trusts who purchased educational courses via local University providers, to offer nurses education on clinical supervision and courses to prepare nurses in becoming clinical supervisors. In the main these strategies appeared to have been adopted with little consultation. Anecdotal evidence from these NHS trusts seems to indicate that education alone fails to establish clinical supervision in practice. The participative and reflexive model underpinning this project resulted in a more creative approach responding to nurses' concerns over clinical supervision. The outcome was that clinical supervision 'got off the ground' and is still in use within the organisation today. It would indicate that the methodological approach in combination with the psychodynamically informed model of supervision has contributed in making this a sustainable initiative.

When the initiative was established in 1997, it reflected the hierarchical nature of nursing as the supervision groups were established by staff grade e.g. G grade groups or F grade groups. A new staff member (F grade) was inadvertently allocated by myself to a G grade supervision group. The mistake was based on the actual role carried out by this nurse, which was leading and managing a service (therefore like a G grade role). This 'mistake' acted as a trigger for re-defining the groups by role function rather than grade e.g. team leader group and service leader group. However, dilemmas continued to emerge through group members being promoted and wishing to continue their membership with their original group. In essence, staff seemed to want to stay working with the group members they had got to know and trust. Over time groups were neither defined by grade or role. The only criteria for group membership were nurses to be F grade and above, and no member should directly manage another group member. At the beginning of the initiative, there was clear feedback from participants that group membership was to be

strictly hierarchical. Over time this situation changed substantially and this positive change came about due to a managerial error and inadvertently challenged the hegemony of hierarchical practices. I felt this reflected a growing understanding of the clinical supervision process with less anxiety and greater openness concerning the boundaries of group membership.

This case study represents my first project in leading and developing an initiative across a nursing service. Academic supervision was provided on an individual basis with a nurse researcher training to be a psychotherapist. This supervision was particularly helpful in supporting me in making the transition into a new managerial role whilst not loosing a research focus. The supervisory process allowed an integration of roles and was a mechanism to examine and manage the tensions within this initiative. This work was influential in my becoming interested in action research and consultative and participative ways of working with people. The project's successes as compared with anecdotal evidence on the difficulties of implementation in other local NHS Trusts were striking. It seemed to indicate that the methodological approach adopted might be an effective strategy for embedding and sustaining change. In addition, this research activity allowed me to integrate theory and practice concerning psychoanalytic approaches to consultation and organisational change. I completed a Master's degree in the application of psychoanalytic theory to organisational consultancy at the Tavistock Clinic in 1998. The management and leadership of this initiative allowed me to integrate theory and practice and gave me confidence in applying the skills learnt on the programme.

This was a formative piece of work in my professional life. Challenges lay in keeping momentum and interest in this work to ensure its profile in strategic organisational development. I was sometimes worried that senior managers' interest was superficial and the initiative seen only in terms of 'ticking the box' on the delivery of clinical supervision. However, I learnt that my enthusiasm does not have to be held in equal amounts by senior colleagues but importantly there needs to be adequate support in the organisation and in particular by those in roles of authority and leadership.

2.12 Discussion

The lessons learned in this case study may resonate and illuminate issues for those trying to support clinical supervision initiatives elsewhere. Indeed, a paper to share the findings more widely has been published in a peer reviewed journal (Ashburner et al, 2004). The approach adopted is well established in counselling and psychotherapy but was innovative in its application for general nurses. Overall in evaluating the evidence, it is possible to recommend a psychodynamic approach to clinical supervision for general nurses. This process was positively evaluated by nearly all participants and was valued for providing opportunities for new learning and development. Sickness findings showed that those in supervision for more than 12 months had the lowest nursing sickness rates in the hospital. The finding in this study concerning staff sickness and supervision warrants further investigation.

The contribution of this case study to the body of knowledge relating to clinical supervision is the transferability of this type of approach drawn from psychotherapy and translated into acute general nursing. This stands as a unique contribution particularly when reports indicate that clinical supervision has been poor implemented and is difficult to sustain in clinical practice (Bishop, 2004). However, this approach to clinical supervision was not without difficulties and in the main related to the struggles supervisees described in engaging with experiential learning and exposing vulnerabilities. This may be indicative of an 'unreflective' nursing culture underpinned by positivism and described by Schön (1983) as Technical Rationality (for further detail see page 17). In addition, examining social defences embedded in the culture of nursing, or as the nurse described challenging her 'protective shell', is potentially disquieting and may lead to some natural resistance (for further detail see page 32). Both factors may hinder the transferability of this approach towards developing more psychologically skilled nurses.

The limitations of this case study relate to reporting findings on a single approach to clinical supervision within one organisation. Interview bias towards positive reporting may have been a factor in staff and supervisor interviews. However, none of the participants interviewed were directly managed by me. This may have helped the participants to talk more openly and frankly about their experiences. However, in light of the fact that the researcher led the project and had a vested interest in its development,

this may have resulted in participants being less critical in their responses. In addition, those staff members who did not volunteer to be interviewed may have done so not wishing to share negative experiences. This potential bias is difficult to address when participants volunteer to be interviewed. However, as the interviewer I tried to make all interviewees feel relaxed and stressed the importance of sharing their experiences whether positive or negative.

There is little doubt that this external supervisory model has ensured the sustainability of clinical supervision within the organisation over four years. However, by its very nature of being 'external', it was vulnerable to being marginalized and not seen as the 'core business' of nursing. Recommendations were made to align this initiative more closely with clinical leadership developments taking place within the hospital.

Reflecting on the process of organisational change, it is of note that less than one third of clinical leaders in this case study took up the opportunity to receive clinical supervision. A range of approaches and models e.g. individual supervision, may have helped to raise levels of participation and would warrant further study. In addition, this initiative did only target clinical leaders and was not open to junior grades of nurses. Interestingly, Teasdale, Brocklehurst and Thom (2001) report greater value being attributed to clinical supervision from practitioners in their early years post qualifying. Over four years this initiative was never extended to junior nurses, despite interview data supporting this development. A tentative hypothesis may be an underlying professional ambivalence (as discussed earlier) contributing to the poor implementation of clinical supervision.

2.13 Conclusion

Findings from this case study suggest that clinical supervision using a psychodynamically informed approach helps nurses acknowledge feelings and see their work from a different perspective, builds confidence, provides support through a crisis and reduces isolation in role. Other findings suggest that, whilst having no impact on staff turnover, clinical supervision might reduce staff sickness. Importantly, not all staff were comfortable with the experiential nature of clinical supervision and there was fragmented attendance at

sessions. This case study demonstrates the transferability of an approach to clinical supervision informed by psychotherapeutic practice into general nursing.

The literature indicates that there is sparse implementation of clinical supervision and a minority of nurses regularly receive clinical supervision (Bishop, 2004; Bond & Holland, 1998). This clinical supervision initiative resulted in less than one third of clinical leaders voluntarily participating, similar to rates reported by Fowler and Chevannes (1998) in their survey of 558 nurses working in the NHS. Interestingly, the particular approach to clinical supervision in this case study did not result in greater levels of participation. Offering a range of approaches to clinical supervision may have improved participation rates. This warrants further study.

Embedding supervision into nursing practice remains a challenge, and this case study offers an approach which proved sustainable over four years. The usage of external supervisors with psychodynamic expertise combined with a participative and responsive managerial approach are two important characteristics of this case study. The lessons learnt from adopting these approaches may be useful to other practitioners trying to embed clinical supervision in practice.

This innovative approach offered nurses the opportunity to see their work from a fresh perspective and a way of "seeing things differently and opening your eyes" (supervisee 2.1 p.6). It has provided new ways of understanding nursing practice contributing to a more 'psychologically minded' nurse. Recommendations from this initiative were the closer alignment of clinical supervision with clinical leadership developments. This challenges Butterworth's (2001) argument that clinical governance is the natural 'home' of clinical supervision in the NHS.

From a personal perspective, this work gave me a great deal of confidence and satisfaction. The approach described in this case study did work well and I feel proud of this achievement. Lessons learnt from this initiative relate to the inherent weaknesses of a 'one model fits all' approach and of the need to offer more flexible and variable options. The disappointment with this work is that only 30% of eligible staff took up the opportunity to receive clinical supervision and it would be interesting to explore this issue in more depth.

To conclude, *The NHS Plan* (2000) identifies that services need to become more responsive and patient-centred where patients are listened to and heard. In parallel, staff need the experience of being listened to and heard. Psychodynamically informed clinical supervision is one way of meeting this need.

2.14 Appendix One: Interview Guide - Questions

Can you tell me about your experience of supervision?
- When did you join the group?
- What interested you in joining?
- How often do you manage to attend?

What is the purpose of supervision for you?
- How are the session organised?
- What do you think the supervisor is aiming to do?
- Outcomes – can you give me an example?

How free do you feel to discuss issues?
- Boundaries
- Confidentiality
- Issues of certainty/uncertainty
- Ownership of the group/attendance
- Quality of interactions

Has it helped you to listen to others?
- Group processes

Can you tell me about your learning from the process?
- Reflective skills
- Interpersonal skills
- Role modelling
- Skills of the supervisor
- Personal relations – you, the team the organisation

How have you dealt with issues of difference and conflict in the group?
- Issues of race and gender

Have you any comments about the project management?
- What changes would you like to see?

How would you like to see supervision developments go in the future?
- Confidence to become a supervisor?
- Support required?
- Resources?

Additional Supervisor Questions:
- Role of the Tavistock group
- Focus upon the styles and approaches used
- External perspective - organisational issues?
- Challenges to the supervision process within the groups

REVIEW OF THE PERSON-CENTRED CARE LITERATURE

3.0 Introduction

This review was undertaken in 2004 during the final stage of my research development and critically examines the literature on person-centred care. From a strictly chronological perspective, the positioning of this literature review chapter between the case study and research report is out of sequence, but its location prior to the research report helps prepare the reader for the next most substantial element of the DHealth. I wish to emphasise that the nature of action research described in the following research report was a consultative process dealing with emergent issues through cycles of action, thus it was only at the end of this process I was really clear about the journey undertaken and the true focus of the study: developing person-centred care. Hence, the selection of this topic for the literature review element of the DHealth in 2004.

The focus of this chapter is two-fold. First, to examine what is meant by person-centred care for older people. This will involve an examination of the theoretical underpinnings of person-centred care and the development of these ideas in gerontological healthcare. This is required to set the scene and explicate the tensions and diversity of meanings concerning person-centred approaches. Second, to review the best available evidence to support such approaches in the clinical practice of long-term care for older people. This particular clinical focus has been selected because of its relevance to the main research element in this doctorate.

3.1 Rationale for an analysis of the concept of person-centred care

The rationale for an analysis of the concept of person-centred care resides in current health and social care policy. The *National Service Framework for Older People* (Department of Health 2001a) and *The NHS Plan* (Department of Health, 2000) represent the boldest and most comprehensive strategy in the past 50 years for transforming and expanding services for older people (Heptinstall, 2001). The identification of person-centred care as

a national standard to be met across the United Kingdom in the next ten years is an important component of the NSF for Older People (Department of Health, 2001a). The aim of the person-centred care standard is:

> "To ensure people are treated as individuals and they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries." (Department of Health, 2001a: 8)

However, Williams and Grant (1998) argue that consumerism underpins the rhetoric of being person-centred. They argue that consumerism involves 'getting close' to the customer to best determine service provision ensuring the patient and not the healthcare provider is at the centre of care. In this chapter, I will argue there are other significant influences underpinning person-centred care beyond consumerism. These other influences are drawn from humanistic psychology and have been widely applied to the 'helping professions', whilst current policy on person-centred care adopts a rather limited, individualised and non-relational approach. An examination of the theoretical underpinnings of person-centred care and the development of these ideas in current nursing and gerontological debates will be the focus of the first part of the literature review.

3.2 Definitions of person-centred care from the literature

Carl Rogers (1902-1987) first coined the term 'person-centred' and is attributed to having first pioneered person-centred approaches to psychotherapy and understanding of human relationships (Kirschenbaum & Land Henderson, 1990). Rogers had an unfailing belief in the innate qualities of human growth and creativity and argued these could be nurtured and developed through positive human relationships. He described innate human creativity as the actualising tendency:

> "I have found that when man is truly free to become what he most deeply is, free to actualise his nature as an organism capable of awareness, then he clearly appears to move toward wholeness and integration." (Rogers, 1990: 27)

Person-centred care from a Rogerian perspective occurs when the following conditions are established in a relationship:

1. Congruence or genuineness with a person

2. Unconditional positive regard (openness to the other) on the issues and behaviour presented by a person

3. Sensitively accurate empathetic understanding of the person's experience

Rogers (1990) described these as conditions of self-worth necessary to release the actualising tendency and therapeutic growth. These are the fundamental Rogerian tenets underpinning person-centred relationships.

Rogerian ideas have had a huge influence on 'helping' relationships beyond counselling and psychotherapy, particularly in education, health and social care (Thorne, 1992). Of particular relevance to this doctoral work is the application of Rogerian ideas in nursing and care for older people.

From a nursing perspective, Binnie and Titchen (1999) describe the utilisation of Rogerian humanistic principles as:

> "a style of practice that demonstrates a respect of the patient as person. The acknowledgement and valuing of each patient's own way of perceiving and experiencing what is happening to him are fundamental to this way of nursing" (Binnie and Titchen, 2001: 16)

From a gerontological perspective, the psychologist Tom Kitwood drew heavily on Rogerian ideas in maintaining the personhood of people living with dementia. He described personhood as:

> "…..a standing or status bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust." (Kitwood, 1997: 8)

From a more recent gerontological nursing perspective, McCormack (2003) has stated person-centred care is about negotiated relationships in which the values of both nurse and patient need to explored and clarified:

> "Being person-centred requires the formation of a therapeutic narrative between professional and patient that is built upon mutual trust, understanding and a sharing of collective knowledge." (McCormack, 2003: 202)

From a healthcare management perspective, person-centred care as defined in current policy, is based upon ensuring:

> "NHS and social care services treat older people as individuals and enable them to make choices about their own care." (Department of Health, 2001a: 8)

The policy makes no reference to the quality of relationships necessary to deliver person-centred care nor the psychological conditions needed to nurture human growth. Instead the person-centred policy agenda is towards supporting individuals in making choices. Although laudable in its aims, this seems rather a misuse of language which promotes a more consumer-orientated approach to healthcare rather than being true to the humanistic psychological origins of person-centredness towards fulfilling human potential. It appears the language of humanistic psychology has been hijacked by policy makers to promote an agenda of consumerism in healthcare for older people. This confusion in orientations illustrates how person-centred care has become a loose and general term that can be used in a 'catch all' way.

3.3 Person-centred care: in depth examination of a 'catch-all' term

This 'catch all' term requires further in-depth analysis to explicate the theoretical dimensions of person-centred care and its application within healthcare, nursing and gerontology. In the following discussion I will examine the theoretical development of person-centred approaches and in particular the work of the humanistic psychologist Carl Rogers. This will be followed by a more focused review of the application of Rogerian

ideas within nursing and the care for older people. Finally, these will be examined against current healthcare management and policy for older people.

3.3.1 Humanistic psychology underpinning person-centred care

Humanism arose in the nineteenth century because of Charles Darwin's divergence with fundamentalists' reading of the Bible over the origins of humanity, resulting in the modern association of humanism with atheism or agnosticism (Lacey, 1995). However, it was not until the 1950s that the term 'humanistic' gained currency particularly in the USA most famously led by Carl Rogers and Abraham Maslow. Humanistic psychology arose out of the dissatisfaction with the more deterministic approaches of behaviourism and psychoanalysis. In the mid 1950s Rogers called his approach client-centred but from the 1970s his work was described as person-centred therapy. This change in name was to reflect that the person was the centre of focus and that Roger's assumptions applied to all aspects of human behaviour, not just psychotherapy and counselling settings.

The central component of Rogerian humanistic theory is described as the 'actualising tendency' which is an innate inclination toward growth and fulfilment that motivates all human behaviour and is expressed in a unique way by each individual (Rogers, 1990). As stated previously the release of this human potential occurs when conditions of self worth are established in a relationship: congruence, unconditional positive regard and empathy. These central tenets of Rogerian person-centred practice will be described in brief.

Congruence or genuineness in a relationship

Rogers (1967) perceived congruence as a condition of a person-centred relationship that demands a genuineness and sense of being real in the moment-to-moment therapeutic encounter. It requires the therapist/practitioner to be confident and to utilise their intuitive feelings. Rogers stated:

> "when in the relationship with his client he *[the practitioner*]* is genuine and without front or façade, openly being the feelings and attitudes which at that moment are flowing *in* him" (Rogers, 1967: 67) (*my addition)

This has echoes of the psychoanalytic theoretical ideas of transference and countertransference in which the therapist's feelings are used as part of the therapeutic endeavour. However, throughout Rogers' prodigious career he never validated the usage of these psychoanalytic constructs in understanding relationships but instead advocated a non-directive approach to working with clients (Thorne, 1992).

Unconditional positive regard in relationships

Rogers (1990) described unconditional positive regard as making no judgments of a client and being open to the person's experience, be this confidence, joy, depression or failure. This relates to the creation of a non-threatening and safe environment. Rogers (1990) believed that the outcome of unconditional positive regard was inevitable human growth and development. This represents an optimistic appreciation of human nature differing from the bleaker deterministic views in psychoanalysis and behaviourism (Thorne, 1992).

Empathetic understanding in relationships

Once the conditions of congruence and unconditional positive regard are in place, Rogers' demanded that the therapist work towards accurately and sensitively understanding the client. This is described as 'the work' of the therapist and Roger's states:

> "Accurate empathetic understanding means that the therapist is completely at home in the universe of the client." (Rogers, 1990: 15)

For Rogers (1990) the empathetic grasp of the client's conflicts contrasted most sharply with a traditional professional diagnostic formulation of a client's experience. Rogers mistrust of this latter professional stance is based upon the belief that all too often that the personal world of the client was objectified by others (Mearns and Thorne, 1988).

Rogerian ideas redefine professional expertise

Rogers' emphasis on the quality of the relationship rather than psychological knowledge *per se* created a challenge to the notion of professionalism and being the 'expert' (Mearns & Thorne, 1988). Rogers (1967) stated that:

> "I feel a deep concern that the developing behavioural sciences may be used to control the individual and rob him of his personhood" (Rogers, 1967:361)

Rogers' work represented a radical shift in the balance of power between professional and client, in which the client's capacity to know themselves (and what was best for themselves) was seen as central (Thorne, 1992). Rogers advocated a move away from technical expertise with greater emphasis on establishing conditions that support the innate potential within human beings for growth. Rogers (1967) argued that expertise resided in the practitioner's capacity to offer a relationship where growth can take place. However, within Rogers' work there was a lack of clarity in the educational preparation needed by practitioners to deliver person-centred care. He went as far as to question formal qualifications:

> "We must face the fact that in dealing with human beings a certificate does not give much assurance of real qualification. If we were less arrogant, we might also learn from the uncertified individual, who is sometimes unusually adept in human relationships." (Rogers, 1973: 365)

Individualism and narcissism: the central weaknesses of humanistic ideas

The existential philosopher and theologian Martin Buber, in a dialogue with Carl Rogers in 1957, was not convinced of the genuine nature of person-centred relationships between client and therapist (Buber & Rogers 1990). Buber argued that there was a lack of reciprocity in the relationship due to an imbalance of power in the therapeutic situation of a person providing help and of the person receiving help (Buber & Rogers, 1990). Buber made the following statement:

> "But your situation has an objection. You *[the therapist*]* have necessarily another attitude to the situation than he *[the client*]* has. You are able to do something that he is not able. You are not equals and cannot ever be." (Buber & Rogers, 1990): 50) (* my additions)

Indeed, Buber went onto to raise concerns that person-centred therapy may develop an individual's sense of self but not a corresponding awareness of others and a sense of social responsibility. Rogers argued that if the conditions for human growth were in

place, then social responsibility was inevitable. In the dialogue Buber challenged this assumed inevitability and argued that the therapeutic encounter may prop up individuality (more certain of uniqueness) versus really living in contact with the world as a person. Here Buber highlights an important tension as to the true extent to which person-centred approaches are relational as opposed to fostering individualism. Rogers' belief in the actualising tendency and the wisdom of the organism was one that was rather non-relational and this, argues Thorne (1992), is a central weakness with Rogers' work. Thorne (1992) argues that humanistic psychology and Rogerian ideas have been criticised for the worship of the self and narcissism.

To conclude, Rogers (1990) identified three conditions: congruence, positive regard and empathy needed to create the conditions necessary to release the actualising tendency. However, a potential weakness with the actualizing tendency is based upon an over emphasis on individualism at the expense of understanding reciprocity and interdependence of relationships (Buber & Rogers, 1990). Despite this criticism, Rogers' influence outside psychotherapy has been extensive and his work is an outstanding achievement (Thorne, 1992). The following discussion will focus upon the application of humanistic ideas into healthcare practice and in particular nursing and care for older people.

3.3.2 The application and development of humanistic ideas: in nursing and care for older people

The application of Rogerian approaches to helping relationships has been extensive (Rogers, 1983; Thorne, 1992; Kirschenbaum & Land Henderson, 1990). The broader application of Rogerian ideas and current humanistic theoretical development in nursing and gerontology will be discussed.

Humanistic ideas applied in nursing

Nursing has a long tradition of wrestling with person-centred approaches underpinned by the humanistic principles (Brown, Nolan, & Davies, 2001). Humanistic ideas developed from dissatisfaction with deterministic ideas and the application of these humanistic ideas in nursing has been far reaching (Benner & Wrubel, 1989).

The broad influence of these ideas is illustrated in the following examples from nursing theory, the nursing process, primary nursing and user involvement. From the 1960s the work of the largely North American nurse theorists was heavily influenced by humanistic ideas e.g. Paterson and Zderad's (1976) theory of humanistic nursing practice. In the UK during the 1970s, Binnie and Titchen (1999) attribute humanistic ideas as being highly influential in the development of individualised nursing care and the nursing process. It offered a relational psychological alternative to task orientated approaches. Kirschenbaum and Land Henderson (1990) argue that Rogerian ideas see the patient as knowing best and have been important in reshaping the nature of expertise. During the 1980s and 1990s these ideas paved the way in nursing for expertise to be seen as residing in the quality of the relationship (Brown, Nolan & Davies, 2001). This has been described as therapeutic nursing by Pearson (1992) and Wright (1990) and was highly influential in the developments of primary nursing and Nursing Development Units in the UK (Binnie & Titchen, 1999). The humanistic ideas of self determination and human growth set precedents for greater involvement and participation of patients in their decisions about their care and current trends in user involvement and participation in nursing (Anstey, 2003; Meyer, 2001). The far reaching and broad application of humanistic ideas in nursing has been highly influential in the professionalisation of nursing offering a theoretical alternative to the biomedical model (Binnie & Titchen, 1999; Dewing, 2004).

Humanistic ideas applied and developed in the care for older people

Rogerian perspectives are growth orientated towards fulfilling innate potential and this offers an antidote to the pervasive negativity of old age (Downs, 1997). The gerontological literature appears to indicate that humanistic ideas are most evident in person-centred dementia care. Woods (2001) argues that the late Tom Kitwood was a major influence in challenging the bleak de-personalised stereotypes of 'dementia

sufferers', pointing out that in contrast people with dementia have feelings, imagination, will and moral being. Kitwood (1997) drew heavily on humanistic ideas and in particular Rogerian ideas. He stated:

> "I became increasingly involved with the details of dementia care, particularly drawing on ideas and practices from psychotherapeutic work, where the emphasis is upon authentic contact and communication... We called the whole approach 'person-centred care' following the example of Rogerian psychotherapy." (Kitwood, 1997: 4)

The individual in person-centred dementia care is described in terms of having 'personhood'. Kitwood (1997) describes personhood as a sense of self-identity maintained by relationships. Self-identity is based upon the unique biographies, personalities and life circumstances of the individual maintained through others. The maintenance of personhood resides with those who are cognitively intact through effective interaction with the person living with cognitive impairment. Adapting Rogerian ideas to dementia care set precedents for valuing the quality of the psychosocial environment and the conditions necessary to support personhood.

Interestingly, the concept of personhood is widely used in the literature of dementia care but is not as well established in other areas of gerontological care. Liaschenko (1997) argues 'person' knowledge (as opposed to case and patient knowledge) takes time to build up and evolves over time and may be most relevant in chronic illness. She questions the value of 'person' knowledge for short-term episodic care which is focused upon cure. Drawing upon Liaschenko's ideas, person-centred practice within gerontology may be most relevant and useful for people with chronic illness when caring relationships are long-term.

Within gerontological nursing, building on Kitwood's (1997) pioneering work in dementia care, several authors advocate a greater recognition on the importance of reciprocity and interdependence of relationships in nursing older people (Clarke, 1999; McCormack, 2004; McCormack & Ford, 1999; Nolan et al., 2002; Dewing, 2004; Malloy & Hadjistravropoulos, 2004). It is important to note the critiques of individualism and narcissism raised by Buber (see page 54 for earlier discussion) are now being developed in

gerontological nursing debates through calls for less individualistic approaches to person-centred care. Nolan et al (2002) believe person-centred care may be better described as relationship-centred care drawing upon the work of the Tresolini and Pew-Fetzer (1994). The Task Force argue that educational curricula across health care disciplines need to recognise the integral part relationships play in the delivery of quality care. This includes relationships between patients and practitioners, practitioners and their communities, across professional groups and managers, and most significantly in relation to the practitioner as a person in the therapeutic interaction with others. Practitioner relationships (inclusive of inter-professional relationships) and the well-being and self awareness required of practitioners were not as clearly emphasised in earlier expositions of person-centred care by Tom Kitwood.

It is estimated that nearly 80% of the support needed to keep frail and vulnerable individuals at home is provided by family and friends (Brown, Nolan, & Davies, 2001) and their strategic importance is receiving increasing recognition, as evident in the Carers' National Strategy (Department of Health, 1999b). These authors advocate seeing family caring beyond the one-dimensional perspectives of burden and stress as dynamic triadic partnerships between the person being cared for, the carer and professional. Indeed, this vision of the triad of relationships in care has led to questioning of the appropriateness of the individual focus and potentially individualistic focus of 'person-centred' care in gerontological debates (Keady, Clarke, & Adams, 2003; Nolan et al., 2003).

3.3.3 Healthcare management and policy: person-centred care as cosmetic sop?

The current Government's modernisation agenda for the NHS has moderated the individualism of neo-liberal market solutions of Thatcherite health policy and replaced the language of 'competition' with 'partnership and collaboration' (Ahmad & Broussine, 2003). However, arguably within current policy there is still a strong moral framework of self-help and individual responsibility that does not signify a radical departure from the previous market-based ideology (Ahmad & Broussine, 2003; Bradshaw, 2003; Blakemore, 2003). The consumerist leaning of the person-centred standard in the NSF is illustrated in the usage of the policy language such as the timely delivery of '*packages*' of care

(Department of Health, 2001a). Nolan, Davies, Brown, Keady & Nolan (2004) argue that the values underpinning this policy are overly individualistic and may not best meet the needs of older people.

Healthcare service improvement towards 'fitting the service around the patient' rather than vice versa is the new policy mantra (Anstey, 2003; Brown, Nolan, & Davies, 2001). This is evident in the recent *NHS Improvement Plan* (2004), which elaborates on delivering personalised care:

> "Between now and 2008, the NHS will be making the changes which enable patients to personalise their care and for those choices to shape the system and the way it is run" (Department of Health, 2004: 28)

However, many authors argue that the values of involvement, choice and participation are bedevilled with tensions and contradictions (Meyer, 2001; Anstey, 2003; Williams & Grant, 1998). The primary tension can be described as bureaucratic in which issues such as finance and the management of demand for health services are weaved into the humanistic ideals of participation and involvement. The following are flaws identified by Williams and Grant (1998) in their explication of consumerist 'people-centred' healthcare policy in Wales:

1. Public services are not just to please, but also to empower

2. Monopolistic supply means seeking alternatives and 'switching services' may not be an option

3. People are more than customers

4. Consumerist values of 'shopping around and seeking redress' are active and aggressive in style and this may not relate well to those who are physically or mentally ill

5. Choice may be an unnecessary burden when a person is vulnerable

6. There are clashing discourses between vulnerable service users and politicians and managers. The latter are concerned with creating an efficient and responsive service whilst the former are concerned with their lives, rights, opportunities and choices

Williams and Grant (1998) argue going beyond consumerism. However, this involves understanding a person's frame of reference around the experience of illness and acting on this frame of reference. Acting upon this frame of reference is more than merely providing information and increasing choice to patients. They argue that socialisation of health professionals needs to be radically changed if practitioners are to really work with a person's frame of reference around the illness experience. Changing the *status quo* in the NHS and being genuinely closer to its clients is indeed a real challenge and consequently current policy perspectives are little more than a cosmetic sop (Williams & Grant, 1998).

3.4 Conclusion

Current Government policy calling for person-centred care for older people (Department of Health, 2001a) is influenced by consumerism and fails to reflect other important underpinnings of this complex concept. These humanistic ideas were born out of frustration with the deterministic principles of the biomedical model, behaviourism and psychoanalysis. In particular, Carl Rogers' work emphasising the potential for human growth and creativity through conditions of self-worth has been highly influential. However, Rogers' work and in particular the actualising tendency has been criticised for being overly individualistic and non-relational (Thorne, 1992). This overly individualist trait of Rogerian ideas has had two important consequences for the development of person-centred care. First, the language of humanistic psychology has been assimilated into the individualism of the consumerist rhetoric underlying Government policy on personalised care. Second, the individualism of Rogerian approaches has been under scrutiny particularly in gerontological nursing. More recently authors call for relationship-centred care with acknowledgement of the mutuality and the inter-dependence of relationships in healthcare (Nolan, 2001; McCormack, 2003; Tresolini Pew-Fetzer Task Force, 1994). Advocates of this approach argue for a re-socialisation of healthcare

professionals in which there is a redefinition of the nature of professional expertise and a much greater psychosocial orientation to healthcare practice. Such systemic changes are necessary to ensure that person-centred care becomes reality rather than a cosmetic sop.

3.5 Examination of the research evidence on person-centred care for older people

The previous section discussed the theoretical developments of person-centred care. This section of the chapter will review the research evidence on person-centred care for older people. Its focus is upon the long-term care (continuing/residential care) as this reflects the arena of care in the research report of the DHealth.

Following the literature review guidelines identified by Hart (1998), the aims of this section of literature review are described below:

1. To determine the clinical evidence base of person-centred care for older people in long-term care settings in line with recent Government policy recommendations

2. To identify the main methodologies and research techniques used

3. To undertake an analysis of the application of person-centred care in practice including the main lessons learnt

4. To identify the gaps in the body of knowledge in applying person-centred care in practice

3.5.1 Mapping the literature

This process will be described in three stages to help the reader understand the literature mapping activities. Stage one was a preliminary sweep of the literature, stage two involved a more focused gerontological review and stage three involved 'non-electronic' approaches e.g. hand searching and drawing on experts in the field.

3.5.1.1 Stage one

The search term used was 'person-centred' to capture information in line with the recent policy recommendations for person-centred care for older people (Department of Health 2001a). In addition this was combined with the appropriate database operator terms to include all derivations of the phrase and American spellings of the term. A preliminary sweep of the literature through all health care related databases available via the Ovid web gateway produced over 1137 hits (English language only) relating to person-centred care, with most material evident in psychologically orientated publications (723 hits via PsychInfo 1872 – Nov 2003). The plethora of literature in the field required a narrowing of literature searching activities in line with the gerontological focus of the main research element in the thesis.

3.5.1.2 Stage two

This second stage involved a more focused search. The results of stage one were combined with appropriate Boolean search terms (and, or, not) along with other basic operator terms including wildcards and parentheses to help narrow the search. Terms searched included 'elder' and 'old' (all literature relating to the conjugation of these stems e.g. elderly, older), 'dementia', 'gerontological', 'geriatric', 'continuing' and 'residential' care. When possible, duplicate citations were removed from within each database. All citations and abstracts were imported to Reference Manager and a repeat check made for duplications. Only articles written in English were retrieved. The following databases and information gateways were searched due to their focus on health care and gerontological issues:

- AgeInfo through the Centre for Policy on Ageing (CPA) 1890 – July 2004
- ProQuest: a) ProQuest Nursing Journals (1988 – July 2004) b) ProQuest Psychological Journals (1992- July 2004)
- PsycINFO 1872- July 2004

- Medline 1966 – July 2004
- British Nursing Index 1985 – July 2004
- EMBASE psychiatry 1980 – July 2004
- CINAHL 1982- July 2004
- All EBM Reviews: Cochrane DSR, ACP Journal Club, DARE and CCTR
- Web of Science – Science Citation Index 1981- July 2004, Social Sciences Citation Index 1981- July 2004, Arts and Humanities Citation Index – 1981- July 2004

In addition, the Department of Health and Social Services web sites were searched. This component of searching activities included all policy initiatives pertinent to the care of older people.

This more focused search focusing on the term as applied to care for older people produced a more manageable number of 124 hits. When required, interlibrary loan requests were made via library services. Each article was read and classified into three broad areas:

1. Theoretical and conceptual contributions to the literature
2. Policy related literature
3. Application in the practice of long term care for older people

3.5.1.3 Stage three

Discussion with experts in the field led to reviewing a number of additional papers. In addition, hand searching journals e.g. Journal of Dementia Care also produced a number of papers (n = 10) not identified through electronic searching. A further 24 papers were followed up from citations made in other articles or book chapters. Four web-sites of

active research centres were also searched for ongoing work and research reports. These papers were classified under the areas described above. For the purpose of this section of the literature review, a total of 105 papers reported on the application of person-centred care in long term care settings and these are critically reviewed.

3.6 An examination of the evidence base on the application of person-centred approaches for older people in long term care settings

This section of the literature review will discuss practice developments in person-centred care for older people in long term care settings and the quality of evaluation in this area. The focus is upon how clinical care is changed and improved (or not) as the case may be. First, there will be an overview of 105 pertinent papers in this field followed by an in-depth analysis of six identified areas of practice emergent from this review. The translation of new theoretical and conceptual perspectives into practice is always challenging due to the inherent difficulties associated with changing practice (Iles & Sutherland, 2001). Putting theory into practice is commonly described as 'walking the talk rather than talking the walk' (Packer, 2000a) and this section explores the literature of those trying to 'walk the talk'.

Categorisation of the 105 papers was undertaken to cohere the diverse applications of person-centred care in practice, to differentiate developments in dementia care and those outside the speciality and to determine the numbers of practice development initiatives and evaluative, empirical research studies reported in the literature. A summary table is presented on page 66. The literature covers approximately 18 years of practice development initiatives with the greatest preponderance of such initiatives occurring in the past ten years reported in 52 periodicals.

The greatest application of person-centred approaches is evident in dementia care. From a total of 105 papers, 74% (n = 78) involved care of people with dementia whilst the remaining papers 26% (n = 27) reported on older people outside of this speciality. From the evidence available, dementia care leads the way in advancing person-centred practice. This situation can be ascribed to the work of the late Tom Kitwood with the Bradford Dementia Group, the Dementia Services Development Centre at Stirling University, the

Alzheimer's Society and the RCN Gerontological Nursing Programme (Veyard, 2001). Substantially less work (n = 26) has been undertaken in non-specialist or generic long term care settings and the literature indicates a gap in the application of person-centred approaches outside the field of dementia care.

Research based papers reporting on the implementation of person-centred approaches amounted to 57% (n = 60) of the total papers reviewed, whilst 43% (n = 45) were descriptive anecdotal practice development projects (inclusive of educationally-orientated examples of best practice). Although the evidence to support the efficacy of person-centred approaches to care in terms of statistical experimental outcomes is extremely limited, there are plenty of small-scale descriptive research studies indicating this approach can produce better patient outcomes, with improved staff morale and quality of care. International research initiatives in this field are led by the research activities of the Bradford Dementia Group in Scandinavia, USA and Japan (Brooker, 2002). It is important to note that large-scale experimental research design involving randomisation to determine population probabilities is methodologically antithetical to the values underpinning person-centred approaches valuing innate human creativity nurtured through relationships (Williams & Grant, 1998).

The literature in this field was fragmented but the following categories were created to draw together the diverse applications of person-care for older people in long-term health and social care settings. Some papers contained elements from a variety of categories, but where this was the case, the strongest orientation in the paper towards a particular category determined the final categorisation (each paper was categorised only once). The identified categories were as follows:

1. Quality of communication and relationships with older people and their families/informal carers to develop person-centred care

2. Development of person-centred care through audit, standard setting and benchmarking

3. Occupational activities and person-centred care

4. Biographical approaches to person- centred care

5. Staff development to support person-centred care

6. Organisational/service evaluation of person-centred approaches

Table 1: Table summarising the major attributes of the literature relating to the application of person-centred care for older people in long term care settings.

	Total numbers of publications	*Speciality of dementia care*	*Non dementia care*	*Descriptive practice development initiatives*	*Research based findings*	*Research example by author*
Quality relating to communication/ relationships	28	20	8	15	13	(Neal & Briggs, 2003)
Audit/standard setting inclusive of benchmarking	22	21	1	8	14	(Innes & Surr, 2001)
Occupational activities	17	15	2	6	11	(Perrin, 1997b)
Staff development	15	12	3	10	5	(Ashburner, Meyer, Johnson, & Smith, 2004b)
Biographical approaches	15	4	11	4	11	(Clarke, Hanson, & Ross, 2003)
Organisation/ service evaluation	8	6	2	2	6	(Pritchard & Dewing, 2001)
Total	105	78	27	45	60	

The six categories emerging from the literature, namely quality of communication and relationships, audit and standard setting, occupational activities, staff development, biographical approaches and organisational/service development, are examined in more detail.

3.6.1 Communication and relationships in person-centred care

From a Rogerian perspective person-centred care is underpinned by the quality of therapeutic relationships. Therefore relevant research into practice development

initiatives in gerontological care will be examined. Twenty-eight papers constitute the literature reviewed on communication and relationships to support person-centred care. The majority of papers (n = 20) are based in dementia care with only 13 empirical research based publications. Five major contributions were found in relation to this category: validation therapy, resolution therapy, malignant social psychology, the senses framework and the negotiation of partnerships with older people. These will be discussed in greater detail below

Validation therapy – an important precursor to person-centred care

Validation therapy was developed by Naomi Feil from the early 1960s onwards for people with cognitive impairments (Feil, 1992). The therapy is based upon the general principle of validation, the acceptance of reality, and the personal truth of another's experience. It is based upon neo-Freudian ideas, Rogerian principles and Erikson's stages of development. Feil saw disorientation and confused speech as a form of communication orientated to resolving conflicts towards the end of the life. The work of the carer and therapist is to view communication, however bizarre and irrational, as having a purpose towards seeking resolution of earlier conflicts, losses and anxieties. Morton (1997) maintains that validation therapy is theoretically weak due to the over-emphasis on psychological determinants of dementia (the assumption being that if people have their feelings validated, progress of the disease will halt) and the 'hotch-potch' of differing theoretical ideas. However, Morton (1997) argues that Feil's clinical work was a radical departure from the standards of her time and exceptionally innovative, being an important precursor to the development of person-centred care for older people.

A review of the literature concerning validation therapy by Day (1997) found initial research reports were based upon case material and clinical impressions, with the first experimentally designed trial appearing in 1986. However, despite an ever-increasing volume of research, Day (1997) states that there is no authoritative basis to support validation therapy. The research evidence on validation therapy is based upon varying methodological approaches, from small-scale descriptive studies (Bleathman & Morton, 1992) to a systematic review of three randomised controlled trials (Neal & Briggs, 2003).

This systematic review incorporated data from 116 patients, and found that validation versus usual care favoured validation therapy (at six weeks), whilst validation therapy versus social contact improved depression levels at 12 months (Neal & Briggs, 2003). Unfortunately, insufficient evidence from the randomised trials (due to different lengths of treatment, choice of control treatments and divergent outcome measures) does not allow any concrete conclusions to be drawn concerning the efficacy of validation therapy.

Bleathman & Morton (1996) reported being surprised at the abilities of those with dementia to fully engage in group therapy (using validation techniques) despite being moderately or seriously impaired. They recommend using rigid procedures including ensuring the same room is used, with a similar seating plan and repeating patterns to open and close a group, in addition to creating an environment of warmth and closeness. These authors argue that validation therapy offers techniques, which continue to advance the humanistic psychological care of people suffering from dementia, as alternative strategies to cognitive behavioural techniques. Although possibly confused theoretically, Feil's work was instrumental in advancing person-centred communication practices and despite insufficient empirical evidence to support this approach, findings reported were generally positive.

Resolution therapy

Two British psychologists, Fiona Goudie and Graham Stokes, developed resolution therapy. It is concerned with the affective state of the person with dementia and the search for meaning and messages behind apparently confused speech (Goudie & Stokes, 1989). These authors are critical of Feil's psychodynamic interpretation of incoherent speech and reject the notion of communication reflecting unresolved childhood conflicts (Watkin, 2003). They argue that dementia creates barriers in communication, and resolution therapy attempts to understand the person with dementia in their current context. They advocate trying to work with the feelings expressed and then deciding how to best meet the needs. Morton (1997) argues that resolution is not a new therapy in its own right but more an application of Rogerian ideas to a new group of clients – people with dementia. This model, Morton (1997) argues, is theoretically simpler and less

confused than Feil's work. Unfortunately, research into the efficacy of this therapeutic approach is very sparse and is largely descriptive (Watkin, 2003). The literature gives no indication of the usefulness of this approach in clinical practice.

Malignant social psychology

Malignant social psychology is a term coined by Kitwood (1997) to describe negative types of communication often unwittingly (and without malicious intent) bestowed upon people with dementia. Drawing upon the work of Goffman (1974) and based upon his observations in residential settings, Kitwood (1997) identified 17 verbal and non verbal mechanisms which undermine personhood. For example:

1. Ignoring – carrying on conversation (or action) as if the person was not there

2. Mockery – teasing, humiliation and making jokes at someone's expense

3. Withholding – refusing to give asked for attention, or to meet an evident need

4. Disparaging – telling a person they are incompetent or useless

This work was not empirically tested but nonetheless strikes a concordant note with the realities of practice and communication patterns in dementia care (Adams, 1996; Dewing, 2004). However, Morton (1997) states that malignant social psychology could be accurately applied in varying degrees to an enormous range of vulnerable people in which there is a significant imbalance of power. Morton (1997) argues that malignant social psychology does not really explain with any specificity the way in which the social psychology around someone with dementia develops. However, despite these criticisms of malignant social psychology, Kitwood's work offers a powerful framework within which to understand and explore the psychosocial milieu and patterns of communication existing in long term care settings.

Less well described by Kitwood (1997) is 'positive person work' which includes such behaviours as:

1. Negotiation – people consulted about their preferences

2. Validation – high degree of empathy in which attempts are made to understand a person's frame of reference

3. Play – spontaneity and self expression

4. Holding – the provision of a safe psychological space for difficult and possible chaotic emotions

He identified that this work needs further elaboration and research. However, the value in malignant social psychology and positive person work lies in the attempts to delineate and describe differing patterns of person-centred communication. His ideas give recognition to the mutuality of relationships and the self-awareness required for those who are cognitively intact:

> "If uniqueness has faded away into a grey oblivion, how far is it because those around have not developed the empathy that is necessary, or their ability to relate in a truly personal way? Thus we are invited to look at ourselves and ponder how we have developed as persons; where we are indeed strong and capable but also where we are damaged and deficient." (Kitwood 1997:16)

A potential problem with this perspective is that families and carers can be blamed (or at least feel guilty) for the physical and mental decline of a person with dementia (Morton & Bleathman, 1995). Kitwood does get around this situation by acknowledging the organic as well as the psychosocial nature of the disease process. However, an important issue is the necessary systems of support for practitioners and family members needed to deliver the demands of 'positive person work'. This important area of practice remains largely neglected in the research literature with only five research based papers addressing this area of practice (see further discussion on staff development on page 84). Dewing (2004) states that evidence of the application of 'positive person work' into practice is limited as it is, as yet poorly developed. Kitwood's work whilst theoretically strong and highly influential, has had very limited empirical testing. Whilst Dementia Care Mapping (DCM) devised by Tom Kitwood and Kathleen Bredin is a powerful and popular audit

tool to evaluate the quality of the psychosocial environment (see p.75 for more detailed discussion), Kitwood's approaches have not been subjected to rigorous cross comparison with 'usual' care, nor undergone economic or longitudinal evaluation. Calls for the development of person-centred care and 'positive person' patterns of communication rely heavily on ethical and moral arguments rather than upon empirical evidence.

The 'senses' framework

This framework identifies the emotional milieu in which positive relationships for both clients and staff within gerontological services can thrive. The framework comprises six 'senses', namely; security, continuity, belonging, purpose, achievement, and significance (Davies et al. 1999; Nolan et al., 2002). The 'senses framework' is largely based upon work undertaken with student nurses in a longitudinal study of the effectiveness of educational preparation to meet the needs of older people and carers (Nolan et al., 2002), and research into the factors influencing good care for older people in hospitals (Davies et al., 1999). This empirical base to the senses framework is to be commended. The authors argue that there is now adequate agreement on what constitutes a 'good life' in older age from a subjective point of view, and that the senses framework has a degree of analytic generalisability. Nolan et al., (2004) do acknowledge further investigation of the framework is required to add robustness. The incorporation of both staff and patient values in the process of caring has moved the debate of person-centred care into the realm of relationship-centred care. Although in relative infancy, this framework is innovative and a conceptually creative contribution to gerontological ideas.

The weakness with the 'senses framework' is that it has not yet been developed to assist practitioners to improve practice. The framework identifies positive atmospheres of gerontological care but gives no indication as to 'how to' build the necessary relationships in practice for better environments of care. A further development of the senses framework is made by Anstey (2003). In her study of involvement of patients and informal carers with continuing care needs, she recommended the addition of 'expertise' as a seventh sense. This stemmed from nurses' impoverishment and lack of involvement in the assessment process, deferring decision making to other members in the multi-

professional team. Future work on the 'senses framework' should focus on how it can be utilised and applied in clinical practice to improve care for older people.

Negotiating partnerships with older people

The empirical work of conversation analysis over one year between nurses (n= 6) and elderly patients (n = 13) in rehabilitation settings underpins the conceptual model for negotiating partnerships with older people as described by (McCormack, 2001; 2003). The findings indicate that nurses exert power and control concerning decisions pertaining to discharge or a transfer in care. Interestingly, McCormack (2001) found that nurses did provide information concerning discharge options, but this alone did not increase autonomy in decision making of participants. He found little evidence of patient's choices and preferences being central to care decisions. The central tenet in McCormack's thesis is the need to establish greater mutuality between the nurse and patient in which values of both parties are clarified in much greater depth (known as a process of 'authentic consciousness') in order to increase patient autonomy. Although McCormack (2001) helpfully offers principles for action, this work does not detail or describe 'how to' change and develop practice. Similarly to the senses framework, this work contributes to conceptual development of gerontological care but has not yet been extensively evaluated or implemented in practice.

Concluding remarks on person-centred communication and relationships

The empirical evidence for person-centred approaches to communicating and forming relationships with older people cannot justify the adoption of a particular approach in practice (Neal & Briggs, 2003). This is a field that is 'ideas rich', offering many conceptual frameworks, but extremely limited in implementation and evaluation in practice. However, the senses framework is unique in its more systemic approach linking both staff and patient experience (Davies et al., 1999). Various authors indicate that imbalances of power exist between older people and formal carers (Feil, 1992; Killick & Allan, 2001; Kitwood, 1997; McCormack, 2001; Morton, 1997). The evidence base for this is determined inductively from observation and description. Greater testing and

development of these models of communication and patterns of relationship with older people needs to take place. In addition, research evidence on 'how to' implement these approaches in practice is urgently required, with economic, cross-comparison and longitudinal evaluation to add rigour to the research evidence.

3.6.2 Development of person-centred care through audit, standard setting and benchmarking

Twenty-two papers constitute the literature reviewed concerning the use of audit, standard setting and benchmarking as strategies to evaluate and improve the delivery of person-centred care for older people. All the papers have an institutional focus with all bar one reporting on activities undertaken in the speciality of dementia care (n= 21). This suggests that dementia care leads the way in person-centred quality improvement within current gerontological practice, but quality assurance outside institutional settings is not well reported. The majority of papers (n= 14) are research based with the remainder (n = 8) reporting on personal experiences in using the tools to develop clinical care. This latter group of publications is orientated to 'lessons learnt from practice' to promote person-centred care and reflects a healthy debate in this area from practitioners involved in quality assurance programmes.

The most established and internationally recognised tool for the evaluation of person-centred care is dementia care mapping (DCM), with a growing research literature in this field (Brooker, 2002). DCM (inclusive of adaptations of DCM) will be reviewed as well as other tools specifically designed to support the development of person-centred care.

Dementia Care Mapping (DCM) and related tools

Two-thirds of papers (n = 15) focused upon the usage of DCM or adaptations of this tool. Of these papers ten were research studies whilst five papers reported lessons learnt from using DCM or adapted versions of DCM in practice.

DCM is an observational tool attempting to measure the positive and negative aspects of the psychosocial environment for people with dementia (Bradford Dementia Group 1997; Younger & Martin, 2000). The tool helps overcome the complex issue that the person with dementia may be unable to comment reliably on the services they receive, and as Brooker et al., (1998) state, a way around this thorny problem is to observe the care they receive. Observational tools are numerous but the uniqueness of DCM resides in not only measuring the quantity of activity but also quality of life (Brooker 1995). The tool evaluates the well-being and ill-being of people with dementia and categorises behaviours over a six hour observation period. During a DCM evaluation each auditor observes between five to ten participants. Behavioural detractors which result in ill-being of those observed are recorded alongside positive event recording when well-being is promoted. It was devised by the late Tom Kitwood and Kathleen Bredin in the late 1980s and in 1992 the first training courses on the usage of the tool took place (Innes, Capstick, & Surr, 2000). DCM is an international method and Innes, Capstick, & Surr (2000) reported 1500 basic users in the UK, 300 in Germany, 20 in Sweden, 300 in the USA and a few users in Australia and Hong Kong. Brooker (2002) describes DCM as both a quantitative and qualitative tool used to evaluate the quality of person-centred care. Ratings of care from 'much improvement needed' to 'excellent' are determined from calculating the group scores.

The DCM Think-Tank publication (Brooker & Rogers, 2001) gives voice to those experienced in using DCM, both researchers and trainers (33 people in total). It represents a collaborative effort to critique and review the tool to guide future development. Key issues raised in the Think-Tank publication and a subsequent publication by Brooker (2002) include:

1. The tool is complex and simplification may improve reliability
2. Recommended inter-rater reliability via the concordance coefficient calculation is 0.8. The lack of ongoing user accreditation will deleteriously effect reliability over time between mapping activities
3. There is good face validity with general concordance and understanding from practitioners

4. Content validity may be reduced through the under-estimation of times of inactivity, social withdrawal and subsequent ill-being as revealed through continuous time sampling (i.e. not observing over a 24 hour period)

5. Internal consistency is adequate

6. Group scores are statistically problematic and the tool is strongest reporting on an individual resident basis over time

7. Future version/s may incorporate a shorter observation period than the six hours of observation recommended in the seventh version

8. A better taxonomy of positive behaviours supporting person-centred care is required

9. Observations are limited to communal areas – what about more intimate personal care activities?

10. Using the tool does not include the direct involvement of people with dementia and this should be re-considered in future developments of the tool.

Constant evaluation of reliability and validity by the Dementia Research Group at Bradford University has taken place for over ten years with subsequently various edition changes (eighth edition to be released summer 2004). Its wide use both in the UK and overseas is a measure of its success and validation by practitioners (Brooker, 2002). An efficacy study of DCM over three years involving 1,614 hours of observation across nine units in an NHS Mental Health Trust demonstrated DCM as a powerful audit tool in which data from DCM showed the quality of care in these units had certainly improved (Brooker et al., 1998). Interestingly, over time staff anxieties concerning DCM decreased (based upon data from 260 anonymous staff questionnaires). However, the researchers report that after three years practitioners still felt a little perturbed in being observed (despite extensive involvement and information) and warn against under-estimating staff concerns and fears.

Findings to support the power and efficacy of DCM as a tool to improve quality of care were also reported in a later but small study by Martin and Younger (2001). They reported that after one year repeated DCM results showed improvements in client well-being in six clinical areas in a large mental health Trust. Organisational changes to build on improvements included increased staffing in two clinical areas, increase in the numbers of nurse specialists and a change in the ward manager role to include more professional development, with investment of time from occupational therapy and physiotherapy and greater person-centred training opportunities for staff. Interestingly, Williams and Rees (1997) report on findings from 13 NHS clinical areas in Wales. None of the areas mapped indicated that significant improvements were required, with all areas being rated 'fair' or above. In contrast, Innes and Surr (2001) mapped 76 people with dementia living in six residential care settings throughout England and found the care offered remained largely physically and task orientated, despite commitment and well intentioned aims to deliver person-centred care in these institutions. The authors argue person-centred care is extremely challenging to deliver in practice. These researchers argue quality could be further improved with more patient contact for registered staff, better key worker systems and activity care plans with greater nurse involvement in activities/engagement with clients and greater inter-professional working. In particular those with severe dementia received care that did not seem to meet their needs adequately.

Perrin (1997b) has picked up this challenge and reports on DCM activities with 197 severely impaired persons with dementia from nine different care settings in the Bradford area. Her findings were less positive than the studies described above. Interaction was minimal and brief with the only active behaviours involving eating/drinking. She was concerned that the weighting of the DCM in favour of positive aspects of care, however minimal, was inclined to mask the superficiality of much of the interaction observed. The most prevalent behaviours recorded in this study were sleeping, staring into space or appearing to be socially withdrawn. Perrin (1997c) questioned the validity of the DCM for people with severe dementia and recommended the use of a tool with a more micro-behavioural focus (Gaebler & Hemsley, 1991). She went on to adapt this latter tool as a new measure for well-being investigating occupational need in persons severely impaired by dementia (Perrin, 1997c). The subsequent positive response schedule (PRS) has

supplemented DCM to evaluate particular interventions in circumstances that require closer scrutiny and finer detail for individuals with severe dementia. Perrin has been systematic and rigorous in her approach and these modifications for people with severe dementia increases the likely validity and accuracy of this tool. She also suggested that staff may feel hopelessly impotent and bury themselves in task activities and suggests that practitioners have to learn how simply to 'be' with people with severe dementia and disability. She reports interpersonal skills of staff to be a vital ingredient to quality of care, stating that formal activities for clients are not necessarily the way to improve quality of care (Perrin, 1997c).

Another modified version of DCM is well-being and ill-being profiling devised by Bruce (2000) and Bruce & Wey (2001). This tool is simpler in design and requires staff to evaluate and score well-being and ill-being of a person with dementia. The tool is designed to encourage staff to reflect on the emotional needs of the residents and to make use of these observations in care planning. It is less systematic and 'quicker and dirtier' than DCM. The tool is designed to promote emotional care but these authors do acknowledge that the tool sacrifices the reliability of DCM as it not based on 6 hours systematic observation. Sadly, no evaluation of validity or efficacy is reported.

DCM and organisational change

DCM is a powerful tool that is widely used in practice and as Woods (2001) states it is most valuable as a catalyst for change with observation sensitively fed back to staff and appropriate action plans generated. DCM works best when incorporated within a quality improvement programme and ultimately the tool's effectiveness is reliant on the context and skills of those who use it. Brooker et al., (1998) state:

> "Commenting on the success or otherwise of an instrument such as DCM is difficult in that so much of its impact will depend upon the context in which it is used and the skills of the people who use it" (Brooker et al., 1998: 67)

A tool that promotes change in organisations should pay greater attention to the organisational conditions supportive of the change process (Brooker 2002; Brooker &

Rogers, 2001). There appears to be a need to make better links with the theoretical and practical perspectives of organisational and systemic change processes as part of DCM. There has also been a keen debate on the organisational conditions necessary to support the development of person-centred care (Brooker & Rogers 2001; Brooker 2002; Neel 2002; Mackenzie, James & Lee 2002). Descriptive evidence suggests that a strong practice and staff development framework is a predictor of success with effective clinical leadership to support change (Brooker and Rogers 2001). Good systems of feedback are needed to ensure that staff morale is not further eroded (MacKenzie, James, & Lee, 2002). The key messages from both practice and research is that whilst this is a powerful tool, it nonetheless creates anxieties for staff being observed and efficacy is ultimately dependent on the organisational conditions in place to support change.

Other audit tools/ standard setting frameworks specifically designed to support the development of person-centred care for older people

Seven papers reported on other tools and standard setting frameworks for developing person-centred care for older people. None of these tools has been subjected to the extensive systematic evaluation and development as evident in DCM.

A manual on person-centred standards for the care of older people with dementia was described by Luckhurst and Ray (1999). This tool was developed as a partnership project between the RCN Gerontological Nursing Programme and the Alzheimer's Disease Society. The standards are arranged into seven categories: moving into a care home, living in a care home, team work, relationships, social activities and opportunities, personal care needs, and the environment. No further work by these authors evaluating this standards framework is evident in the literature.

Person-centred modifications to the benchmarking tool, the Essence of Care (Department of Health 2001b), were proposed by Baker, Edwards and Packer (2003). The benchmark tool has six factors identified in the person-centred care element: an assessment of need, providing person-centred support, monitoring person-centred care, reviewing person-centred care, user and carer involvement, organisational strategy. This

framework has only recently been developed but the authors report a phenomenal interest. However, no research studies report on the usefulness of this tool in practice.

Quality of Interaction Schedule (QUIS) was designed as part of the evaluation of a philosophy of care for elderly mentally ill people transferred from long-stay mental hospital to smaller and more homely environments (Dean, Proudfoot, & Lindesay, 1993). The broader clinical focus including people with chronic and enduring mental health problems meant this study was the only one categorised outside the speciality of dementia care (although people with dementia did participate in this study). Unlike DCM this observational tool does not report on client well-being *per se*, but offers feedback on the amount and quality of communication and activities taking place within a unit. This tool was subjected to rigorous testing with adequate inter-rater reliability (concordance co-efficient = 0.7). It is a tool frequently used by the independent 'watchdog' charity, the Health Advisory Service (HAS 2000), as part of its remit to independently report good and bad practice to ministers and to offer advice and support to local services in promoting dignity and respect for older people receiving health and social care. The tool has been widely used across a range of elderly care services by HAS 2000 service evaluators (personal communication with HAS 2000 team member). However, formal evaluation of the tool in practice appears sparse.

To conclude, the evaluative frameworks and tools listed above to develop person-centred care have almost entirely arisen from environments supporting people with dementia. This may be attributable to the difficulties and challenges of obtaining reliable feedback from people with dementia on the quality of care. DCM certainly tries to address this issue and the evidence suggests that this is the most powerful tool available in improving person-centred practice. From the literature, the second most rigorously tested tool is QUIS. This tool has a broader application outside of dementia care to more generic health and social care settings for older people. The use of QUIS by HAS 2000 is an indicator of its usefulness and relevance in improving practice. Ultimately all tools are dependent on the skills of the people using them and the context and conditions in which they are used.

3.6.3 Occupational activities

Purposeful appropriate activities and stimulation of the senses is an important component of maintaining personhood in long-term care in order to address the boredom and apathy often associated with institutionalisation (Kitwood, 1997). From a review of observational studies of institutional care for elderly people Brooker (1995) indicated most evaluations found that people living in long stay settings spend long periods doing nothing. Perrin (1995) asserts that purposeful activity is a fundamental human need that is often neglected in institutional settings. Kitwood (1997) stated that many people with dementia in institutional settings spend long periods without human contact and suffer subsequent psychological withdrawal, reduction in self-esteem and exacerbation of 'disruptive' behaviours e.g. screaming or faecal smearing. This evidence is based on his observations in residential settings for people living with dementia. Perrin (1995) states:

> "it cannot be denied that until very recently, life for most elderly people in long-stay care, has consisted in daily 12 hour periods of chair sitting (or possibly corridor-pacing), punctuated spasmodically by brief food or toilet experiences" (Perrin, 1995: 69).

Seventeen publications within the literature reviewed concern occupational activities. The majority of these papers were based in the speciality of dementia care (n = 15) and were research based (n = 11). In relation to literature on person-centred approaches to occupational activities, the strongest evidence base exists within the speciality of dementia care.

Nearly ten years ago Perrin (1995) argued that there was no research evidence to support the place of music, dance, physical exercise, massage, facials, cooking, gardening, flower arranging and other multi-sensory activities. Today, the evidence base has significantly increased including a systematic review on the use of multi-sensory stimulation (known as Snoezelen) (Chung et al., 2003) and small scale project evaluations e.g. a collaborative project between a service for people with dementia and a local arts development team (Wood, 2003). Evidence to support positive effects of activities, e.g. a 90 minute walk five times per week, on behaviour and well-being of residents with dementia is reported

in a systematic review by Opie, Rosewarne and O'Connor (1999). The evidence in this field draws upon a variety of methodological approaches and exemplars from this variety of approaches will be discussed below.

Small scale descriptive studies

Five small descriptive studies relating to activities and creative arts used pre-activity, during activity and post-activity evaluations to ascertain effectiveness with people with dementia. One project reported on the well-being of 19 people with dementia on an outdoor activity holiday (Brooker, 2001), another reported the introduction of two social care support workers in a care home to assess occupational need and deliver individualised activities programmes for 7 residents (Pool, 2001). The third project looked at singing as part of everyday care for nine people in a specialist facility (Brown, Gotell, & Ekman 2001), another project reported dance activities for people with dementia (numbers involved not specified) (Kindell & Amans, 2003) and Maguire & Gosling (2003) evaluated an activity and stimulation group for four to six residents. All studies reported increases in well-being during activities. However, only one of the projects (Pool, 2001) reported any longer term improvement post intervention and although Brooker (2001) found no changes in residents' well-being using DCM, staff reported improved relationships (post holiday) not captured by the usage of DCM as a tool. The Brown, Gotell & Ekman (2001) work although innovative (introducing staff singing to everyday care activities), was over zealous in its recommendations stating that changes could be spectacular. The authors gave little attention to the weaknesses of their study design, or advocated more long-term evaluation. A characteristic of this work is the enthusiasm evident from those involved, as reported by Innes and Hatfield (2002), but Crump (2002) found some authors a little evangelical. Research into person-centred approaches in this field is still in its infancy, erring on the uncritical at times, but ongoing small scale evaluation may best contribute to practice knowledge in this area (Perrin, 1997a).

Action research

Two action research studies report on the value and lessons learnt from creative arts work with people with dementia (Cotter et al., 2001; Rose Schlingensiepen, 2001). Both projects comment on how arts projects in institutional care settings bring together two very different worlds and cultures, and emphasise the need to work in a systemic way with managers, staff and clients. Rose & Schlingensiepen (2001) state cultural differences need to be taken into account by all parties; if not, the project will fail to reach its potential or may have the capacity to disrupt. They advocate the need for musicians (and indeed all artists involved in working with older people) to have training through working with more experienced artists and de-briefing sessions. The authors argue the benefits are truly equalising when artists gain from people with dementia and vice versa. However, an interesting caveat of this work is the potential for arts worker to disempower carers through unconsciously undermining staff confidence. Cotter et al. (2001) report the benefits of creating opportunities through the arts for both clients and staff to be together and have fun and enhancing communication between staff and the person with dementia. However, these authors also report on some staff struggling to engage with loss and negative issues raised by participants. This inter-professional action research project described how some staff groups were less well equipped to work in creative ways, highlighting the issues of the support staff need to move away from an organic model of understanding the person. Frances (1999) states that there is virtually no policy concerning older people and the arts, either in major arts institutions or in any major institution working with older people. The lack of policy means that people are working in the arts in relative isolation with inadequate planning, research, training and information (Frances 1999).

Clinical controlled trails

A systematic review of Snoezelen (providing multi-sensory stimulation of sight, hearing touch taste and smell through lighting effects, tactile surfaces, meditative music and the odour of relaxing essential oils) from two clinical trials could not determine clinical efficacy due to differences in methodology and control conditions, although the trend was in the direction of favouring treatment (Chung et al., 2003). However, as

MacDonald (2002) states multi-sensory approaches frequently take place in special rooms providing an unfamiliar environment and experience for people with dementia. This author argues that little or no significant differences have been found between multi-sensory stimulation when compared with participants receiving one to one attention. Reflecting on his experiences as a researcher and practitioner involved in multi-sensory interventions, MacDonald (2002) states that efforts should be made to bring back rich sensory experiences into everyday care to enrich impoverished environments e.g. a walk in the garden, the smells of food, relaxing bath time.

A large randomised controlled trial (n = 127 subjects) tested a variety of interventions - an activities of daily living intervention, a psychosocial activity intervention and a combination of the two to determine the efficacy in reducing disruptive behaviours in nursing home residents with dementia as compared with two control groups (Beck et al., 2002). Project nursing assistants were trained and delivered the interventions five days per week over a 12 week period. The treatment groups did not show a significant reduction in disruptive behaviours but did demonstrate improvements in mood. However, what is most interesting from this study is that at one month and two-month follow-up (after the withdrawal of the project nursing assistants) there was a worsening of disruptive behaviours across all groups. This is ascribed to the increased time and stress placed on staff remaining in the nursing homes (without the support of the project nursing assistants), and lack of continuity in staff. The authors do not raise the ethical issues of this research concerning the withdrawal of the intervention. Paradoxically, although not stated by the authors, this study does indicate the real value of relationships for people with dementia (and the effects of when they are withdrawn or changed) and the importance of working with and alongside staff to support change and improve the quality of care. Perrin (1997a) recommends that small-scale action research is the best methodological approach to developing practice in this area, as large randomised control trials on the efficacy of certain activities negate the values of person-centred care.

Conclusion on the research evidence to support occupational activities

The engagement of people in purposeful and appropriate activities/stimulation of the senses is valued due the potential benefits in participants' well-being (Brooker, 2001), improved communication and understanding between staff and residents (Brown, Gotell, & Ekman, 2001; Cotter et al., 2001) and mutuality of enjoyment for both staff and residents (Kindell & Amans, 2003). The literature is generally positive and supportive of changes in practice. However, there needs to be greater reporting of sustainability and difficulties encountered. The action research studies (Cotter et al., 2001; Rose & Schlingensiepen, 2001) stood out as reporting on lessons learnt and difficulties in developing purposeful activities in practice. The challenge lies in incorporating 'activities' into everyday care as identified by MacDonald (2002). This may support long-term change and improvement as reported by Pool (2001) in the establishment of an activity model of care. This area needs a great deal of further research.

3.6.4 Staff development and person-centred care

The vital ingredients in the delivery of person-centred care are the attitude, skills and knowledge of staff in creating a positive, nurturing and developmental environment for older people (Kitwood, 1997). Interestingly, research concerning staff development to support person-centred practice appears sparse with only 5 research papers from a total of 15 papers reviewed in this important area. Jacques and Innes (1998) argue that even more limited is research relating to health care assistants and their role in developing person-centred care. The majority of publications report on staff development in dementia care (n = 12). Drawing upon her practice experience in dementia care, Packer (2000b) states that knowledge is not enough and that there should be a move beyond simplistic training interventions if person-centredness is ever to infiltrate institutional care. Both researchers and practitioners advocate clinical supervision, mentorship, critical incident analysis, effective appraisal systems, positive role models as well as formal educational activities to support person-centred care (Kitwood, 1997; McCormack, 2001;

Cheston & Bender, 2004). However, these recommended practices are based on anecdotal and intuitive evidence rather than on empirically tested evidence.

Jenkins & Allen (1998) undertook a study that successfully elucidated the relationship between staff burnout and a reduction in the quality of interactions with older people in residential settings. However, the sample size (n = 18) was small and the researchers caution against assuming causality between variables. In addition they were able to show that staff who felt more involved in decisions relating to their work showed fewer negative interactions with residents. Innes (2001) from her evaluation of an educational programme in dementia care states there is a need for training and education following person-centred principles. In support of this position, an action research project in a 50 bed nursing home illustrated how training alone was not enough to change practice (Lintern, Woods, & Phair, 2000). The research showed that, despite a change in staff attitude and knowledge after a two-day person-centred training programme, the well-being of residents did not improve. It was only through leadership development activities and collaboratively devised action planning that resident's well-being started to significantly improve. DCM and a tool to assess a practitioner's knowledge of person-centred care (known as the Dementia Practitioner Care Assessment) were the two tools used at baseline, post training, phase two (six months later) and phase three (12 months later) to evaluate change. The phase two action plans included:

- Not discussing care in front of patient
- Engaging residents in purposeful activities
- More attention to residents with greater disabilities
- Developing residents' profiles
- Facilitation of residents who wished to wander
- Discontinuation of staff rotation to promote continuity of care
- Supervision of senior managers

- Appointment of a part-time practice development nurse.

The third intervention phase (after 12 months) saw a range of action plans:

- Creating a more stimulating environment for residents
- Communicating the home's philosophy to agency and temporary staff
- The introduction of a staff overlap to improve communication between shifts
- New induction systems for staff
- Replacement of clinical uniforms with more casual dress code
- Increasing the garden area.

It was only after the third phase that significant changes in resident well-being were found and the quality of care had improved. This positive change took place in the context of greater staff continuity, improved staff involvement in handovers, more staff meetings, better staff induction and training opportunities. They identified that a cohesive management team was the key ingredient for success in delivering person-centred care. The research findings of this action research project are supported by the practice experience over eight years of Christian Mueller Hurgl in Germany, who states:

> "education of individuals without advances in staff and organisational management at the same time ends, in many cases, in a change in job: the person leaving the caring professional altogether or starting to study nursing science" (Mueller Hurgl, 2003: 8)

Mueller Hurgl (2003) argues that an organisational approach to education needs to be adopted and that this is currently being evaluated in Germany (to be completed in 2005). Within the UK, a large action research project involving the seven nurses in research and development roles in a variety of NHS organisations, concerned with improving care for

older people, sought to integrate research, education and practice to improve practice. A more integrated cross-boundary organisational approach showed that positive improvements in the quality of care took place in a range of care settings (Meyer, Johnson, & Bryar, 2004). Findings from one study site in this project reported on how systems of weekly team supervision for staff, an action learning set for managers linked with a clinical initiative of collecting life histories with residents in a NHS nursing home resulted in improvements of quality of care (Ashburner et al., 2004). From the five projects described above, evidence supports systemic approaches focusing on working with managers to support staff development and the change process.

The research area that appears to be largely unaddressed is the extent to which practitioners have to engage in an understanding of themselves in order to work in a person-centred way. In other words how the personal biography of the carer impacts on abilities to care for others. This is spoken of in terms of practitioner self-awareness in the Pew-Fetzer Task Force (1994) on relationship-centred care. Kitwood (1997) described this as the 'experiential self' of the care worker familiar with the world of feelings, accepting their own vulnerabilities and able to live with a low level of psychological defence. Packer (2001) describes the importance of care workers finding time to communicate with oneself and recognising co-dependency (meeting psychological needs through caring for others). Interestingly, research and evaluation in this area appears extremely limited despite it being such a key component of person-centred care.

3.6.5 Biographical approaches to care

Biographical approaches to care are focused upon the collection, sharing and recording of life history information i.e. who you are as a person. These approaches stem from the conceptual basis that maintaining personhood requires each individual to be appreciated in his or own uniqueness (Kitwood, 1997). Polkinghorne (1996) argues that conventional models of care are limited to the general knowledge of which interventions are likely to be effective in treating a particular diagnosis, and that expert clinical decision making with older people requires biographical knowledge over and above such conventional approaches. Goldsmith (1996) and SNMAC (2001) point out that there is often an

appalling lack of *personal* knowledge (as opposed to the diagnosis and prognosis of the disease) about older people in institutional settings. Knowledge of physiological problems alone limits the possibilities for meaningful interaction and understanding of behaviours. Goldsmith (1996) goes on to describe the value of the life story:

> "People build up patterns of behaviour during their life, and they often retain their behaviour patterns during their time of illness. It helps our approaches, and our attempts to communicate, if we can appreciate these patterns." (Goldsmith, 1996: 86)

Research into biographical approaches in gerontological care is lacking conceptual clarity or operational definitions (Webster & Haight, 1995). This lack of conceptual clarity makes it difficult to differentiate those studies specifically underpinned by person-centred values. In addition, the literature related to the use of biographical approaches in clinical practice lacks empirical and longitudinal evidence. However, 16 papers are included in this review. The evidence to support this practice is largely descriptive (12 papers) or anecdotal (4 papers). Most reports appear over the past 15 years (Bornat, 1999). For purposes of clarity Goldsmith's (1996) description of different biographical approaches is helpful and is as follows:

1. Reminiscence as the sharing of memories

2. Life story as an individual approach to share information about a person's life, usually (although not necessarily) in the form of a scrap book or booklet

3. Autobiography – a comprehensive account of a life where the subject is the sole author

4. Oral history – mainly done in groups, whose main concern is the retrieval of past experiences and their recording or preservation

5. Life review as the process of going over a person's life with a view to understanding or 'unpacking' certain events

The two most common initiatives in health care are reminiscence and life stories (Goldsmith 1996). For the purpose of this review these two biographical approaches will be explored in more detail due to their popularity and prevalence in practice. Both life history and reminiscence initiatives share the common thread of looking back on the past and sharing this with another individual or in a group. However, Clarke (2000) argues that life stories, in contrast to reminiscence, uncover much more than people's past lives; they allow an exploration of the most recent past, the present and future concerns or plans. The activity is more structured with less spontaneity than reminiscence (Webster & Haight, 1995). These distinctions between the two activities are helpful.

Reminiscence

The practice of reminiscence has a long history in gerontological care (Butler 1963; Kitwood 1997). From a conceptual perspective reminiscence is part of person-centred care through validating personhood by valuing past experiences (Bornat, 1994). However, in the majority of the eight papers reviewed this conceptual perspective is implied rather than overtly using the term 'person-centred care'.

From research undertaken over ten years with older people living in sheltered housing, Coleman (1994) reported on distinct attitudes of older people towards reminiscence: treasuring and enjoying relating experiences, being troubled by memories of regret, seeing no point in spending time on the past, or active avoidance because of the sense of loss it produced. This work explains why there is no simple link between reminiscence and well-being and why in certain circumstances reminiscence may not be helpful or appropriate. The implications for practice relate to the sensitivity required in meeting different people's needs and he (1994) raises concern about the uncritical use of reminiscence in practice. However, there are many reported benefits to reminiscence for participants including increases in self esteem and self worth for older people who voluntarily engage in the process (Haight & Webster, 1995). However, the literature in the main tends only to provide a 'snapshot' and fails to evaluate outcomes over time. The evaluation of staff's perceptions and experiences of reminiscence is under-

investigated, indeed a much greater research focus is on the older person's experience of the process (Bornat et al., 1998).

Reminiscence work is described as complex with a dichotomy of practice (Bornat et al., 1998). This dichotomy is described as consisting of:

- reminiscence as a group process generally bringing confidence and pleasure to participants

- reminiscence as a more individual psychological approach which may evoke ambivalent and conflicting emotions towards the end of life.

Indeed, Mills (1999) suggests that the links between memory and emotion are strong which raises the psychotherapeutic aspects of this activity. Mills (1999) recommends staff training on the sensitivity and ethics of biographical practice and states:

> "Many practitioners may feel uneasy with a seemingly indiscriminate 'rummaging' in the memories of frail and dementing elderly, and will wish to establish firm guidelines for practice." (Mills, 1999: 19)

Goldsmith (1996) argues that current professional qualifications and usual work practices seldom equip care staff for biographical approaches to care. This is supported by Bornat (1999) who states that National Vocational Qualifications (NVQ) system of qualifications have not supported or legitimated biographical or reminiscence based approaches to care.

There is little experimental work in the field. A systematic review of reminiscence therapy for people with dementia found only one trial with extractable data but not statistically significant findings indicating a lack of evidence regarding the effectiveness of reminiscence therapy for people with dementia. This highlights the need for more systematic research in this area (Spector et al., 2004). A pilot randomised controlled trial of a reminiscence intervention for 11 people with dementia over 20 weeks did show improvements as compared to the control group and a larger multi-centre randomised controlled trial is now underway (Thorgrimsen, Schweiter, & Orell, 2003).

Life stories

Eight publications report on life stories and their incorporation into person-centred approaches to care. The conceptual links with person-centred care and life stories (as compared to reminiscence) are made more clearly. Two studies report findings within the speciality of dementia care.

There appear to be two main foci in life story research/practice development: seeing the person beyond the stereotypes of old age and the diagnostic labels, and the subsequent relationship change this brings about between practitioners, carers and service users. These foci are typically presented by Batson, Thorne & Peak (2002) in the evaluation of a project in which nine life histories were collected by experienced dementia workers with clients living at home or in residential settings. The life history information was collected in a 20-30 minute session on a weekly basis, but the authors fail to report over how many weeks these sessions took place. Semi-structured evaluative interviews were undertaken with four 'tellers' (people with dementia), five informal carers and nine staff who facilitated the sharing and collecting of life history information and devising individual life history booklets. Findings reported by Batson, Thorne & Peak (2002) indicated that the life story 'tellers' responded positively to the experience but commented on the sense of frustration over memory loss. Informal carers also positively evaluated the project but felt the well-being of the 'teller' was only short lived and their relationships with the teller remained unchanged. However, carers really valued the time the staff spent with their family member and the interest shown in the life history information. The staff reported greatest change in understanding the person telling the life story and eight staff members felt their relationship had changed positively. Staff also reported positively on meeting with the wider family of the person with dementia and three staff reported on improved relationships with informal carers. Difficulties reported by staff involved the time taken to collect the information and two staff commenting on the emotionally demanding nature of the process.

Other reports on life stories outside of dementia care also emphasise the positive impact on staff perceptions towards the older person's situation and staff changing their perceptions and relationships with older people (Clifford, 1999; Wells, 2003; Clarke, 2000; Clarke, Hanson, & Ross 2003). In addition life history books may be used between

different care agencies or to support transitions between care (Murphy, 2000). However, the projects described are all small-scale and exploratory in nature and a hypothesis of better relationships between service users, formal and informal carers subsequent to the collection of life history information remains tentative and unproven. However, from this limited evidence base, sharing life history information could be a useful strategy to change and improve relationships between service users and formal carers and improve relationships between both formal and informal carers. This area of practice deserves much greater attention and Clarke, Hanson and Ross (2003) advocate longitudinal action research to investigate biographical approaches more fully, and how they can be integrated with the culture and management of gerontological care.

Overall, the evidence on life histories and their impact on care is descriptive in nature and has not been submitted to experimental testing (Clarke, 2000; Palmer, 1999). Although there are keen advocates for this approach to care (Kitwood, 1997; Polkinghorne, 1996) the empirical base to support this activity is limited. However, the evidence from the literature on life stories, as compared to reminiscence, does make greater comment on the potential change in relationships and perceptions between practitioners, the client and family member as compared to the literature on reminiscence. Concern is raised about current education and training opportunities inadequately supporting biographical approaches to care (Bornat, 1999; Goldsmith, 1996; Mills, 1999).

3.6.6 Organisational evaluation and person-centred care

The seemingly classic study in this area is a prospective evaluation of two residential units for the elderly mental ill carried out by Dean, Briggs and Lindesay (1993). This study involved residents and staff assessed at baseline in long-stay hospital mental health wards, and at 3 months, 6 months and 12 months after the transfer to smaller purpose built facilities (each resident having their own room) underpinned by a particular philosophy of care (the domus philosophy). This philosophy was based upon the following aspects:

1. Resident's home for life

2. The needs of the staff are as important as the residents

3. To work therapeutically with people in which psychological and emotional needs may take precedence over the physical aspects of care.

Although the philosophy does not technically use the label of person-centred care, the values underpinning the domus philosophy are person-centred. This study showed that traditional institutional care can seriously exacerbate cognitive impairment and that it is possible to reverse this impairment by improving the social environment. Compared to baseline, substantially higher levels of activities and interpersonal interactions were found at follow-up in the new care settings. This suggests a more enriched environment. However, the research was unable to comment on the sustainability of the improvements beyond the initial enthusiasm of the first 12 months.

Few in-depth dementia service evaluations are documented (Pritchard & Dewing, 2001). These authors evaluated the SPECAL service (Specialised Early Care of Alzheimer's). This multi-method evaluation included interviews with service users with dementia and their carers. This interesting service is designed to provide early care and to pro-actively prevent crises and demonstrate what a person with dementia can achieve. The service is based around a respite care and assessment unit and supports the transition to long-term care. The well-being (assessed via DCM) of residents involved in the care offered the SPECAL team was very high, and interview data showed service users valuing staff who listen. Indeed the supportive managerial and organisational culture of the service were highlighted as important and seen as a great strength. Pritchard & Dewing (2001) report that innovative services need the support of shared cultures across organisations in order to thrive.

Both the above studies demonstrate the benefits of person-centred environments and evaluate the positive effects of new services. However, this research is extremely limited and further economic, cross-comparison, longitudinal evaluation is required in order to be conclusive.

3.7 Discussion on the evidence reviewed

The broad reaching policy demands for person-centred care as laid out in the NSF for Older People (Department of Health, 2001a) is not based upon extensive empirical evidence. The most extensive evaluations of person-centred care has taken place in dementia care; 74% (78 papers) of the literature reviewed involved people with dementia. The evidence to support the broader application of this approach outside of dementia care is extremely limited. Liaschenko (1997) suggests 'person' knowledge in healthcare may be most appropriate in chronic, non-curative situations as 'person' knowledge takes time to appreciate and understand. Indeed she argues person-centred care may not be appropriate in short-term episodic healthcare. However within current policy, person-centred approaches are being advocated across all of gerontological care. The evidence base to support this broader application beyond dementia care is extremely weak, and according to Liaschenko's position, may not be suitable across the whole healthcare spectrum. This indicates a current gap in knowledge with minimal evidence available evaluating the application of person-centred approaches beyond dementia care.

The evidence base around person-centred care is generally small-scale descriptive research. Methodologically this is most appropriate for the evaluation of person-centred approaches as it is in line with the values underpinning the approach, and concerns have been raised by Williams and Grant (1998) and Woods (2001) as to the appropriateness of large randomised controlled trials in this field. Most research evidence is associated with DCM and this powerful tool has been subjected to extensive testing and evaluation. The tool is both quantitative and qualitative in design and has a proven track record in improving the quality of person-centred care when part of an organisational quality assurance programme (Brooker et al., 1998). Person-centred care is well described conceptually but the empirical base to support practice is relatively weak. The challenges of implementing a conceptual idea into practice i.e. 'walking the talk' rather than 'just talking the walk' make action research a particularly suitable methodology (Perrin 1997a).

There is little doubt as to the challenges in implementing person-centred care. This is a positive and nurturing approach to care that is diametrically opposed to the bleak, negative stereotypes of traditional custodial 'geriatric care'. Working to challenge these stereotypes is not easy and is frequently described as an uphill struggle (Packer, 2000a;

Packer, 2000b). Lessons learnt from implementing person-centred care are largely reported anecdotally through practice development initiatives. Systematic evaluation of the change process is captured in four action research studies and key messages from all of the literature include:

1. Training alone is inadequate to support person-centred improvements in practice, and work with managers is necessary to effect change (Ashburner, Meyer, Johnson, & Smith 2004b; Lintern, Woods, & Phair 2000)

2. Supportive managerial and organisational cultures are needed to deliver person-centred practice (Brooker, Foster, Banner, & Payne, 1998; Pritchard & Dewing, 2001)

3. DCM evokes staff anxiety and skilful feedback of DCM findings needs to take place (Mackenzie, James, & Lee, 2002; Neel, 2002)

4. Healthcare assistants are often ignored in research studies (Jacques & Innes, 1998)

Current gaps in the research within long-term care settings relate to research evidence on the necessary skills, knowledge and attitudes of staff required in the delivery of person-centred approaches. The fewest number of research based articles was found in this area (n= 5). This does seem somewhat paradoxical when Kitwood (1997) so clearly perceives the quality of person-centred care as being largely determined by the self-awareness and skills of carers. This is a gap in the knowledge base that needs to be addressed.

3.8 Conclusion

The evidence of the benefit of person-centred care to nursing practice in long term care settings is largely descriptive in nature and lacks an experimental evidence base. It is unsurprising that the experimental evidence base is weak as population probabilities (integral to randomised controlled trials) are at odds with the values underpinning person-centredness (Williams & Grant, 1998). Small-scale action research is recommended by Perrin (1997a) to develop theory and practice in person-centred care. There is evidence

that this recommendation has been taken up through the work of the following researchers: Ashburner et al. (2004b); Cotter et al., (2001); Lintern, Woods and Phair, (2000), but much greater developmental work on the application of the concept of person-centred care in practice needs to take place (Dewing 2004; McCormack 2004; Nolan, et al., 2004). The most extensive research in the application of person-centred approaches in gerontological settings has occurred in the field of dementia care. The application of person-centred approaches to more generic care for older people is a current gap in the literature and needs further development. In addition, research evidence on staff development issues appears particularly sparse and needs to be addressed.

AN ACTION RESEARCH STUDY TO EXPLORE THE DEVELOPMENT OF PERSON-CENTRED CARE FOR OLDER PEOPLE

4.0 Executive Summary

This is an account of developing person-centred care through action research within an NHS continuing care service and is the substantive research element of the DHealth. The project described in this research report was part of a larger educational consortium funded initiative; the CELEC Action Research Project: Care for Older People (CARP). CARP was established through recognition of the need to blur the boundaries between education, research and practice development to support change and improvement in gerontological care. Seven posts (Lead Research and Development Nurse: Care for Older People) were funded for three years to improve care for older people in central and east London. The post holders undertook a range of action research projects in diverse health care settings (mental health, primary health, and acute services). All the projects were developed to meet local NHS Trust agendas.

This report describes and evaluates the action research activities undertaken at one of the research sites. The project aimed to support staff in developing person-centred care in a NHS nursing home. For the purposes of this project, person-centred care is based upon fostering respect and dignity for both residents and staff living or working in this long-term care facility.

Action research is a methodological approach particularly suitable for the evaluation of organisational change and development (Hart & Bond, 1995). The approach is about undertaking action and studying that action as it takes place (Coghlan & Brannick, 2001). In addition, this project paid particular attention to psychodynamic approaches to supporting change. Six interventions/action cycles took place to support the development of person-centred care:

1. The collection and sharing of residents' life histories

2. Weekly team supervision meetings for staff and monthly external supervised meetings for both the action researcher and senior manager.

3. An action learning set for managers in older people's services

4. The establishment of a user and carer group

5. Training and audit activities on person-centred care

6. Building links and networks with local organisations

This report describes the processes and outcomes of change through working in a collaborative way. At the close of the project, both staff and residents reported higher levels of satisfaction with the service. Repeat baseline audit findings and organisational performance indicators showed improvements in person-centred care, the quality of nursing care provided, the quality of interpersonal interactions and the management of the home.

The positive outcomes were achieved through a psychodynamically informed approach to action research and organisational development. Given that current policy indicates the need for person-centred care (Department of Health, 2001a), this report provides useful strategies for putting this into practice.

4.1 The story

4.1.1 Introduction

The project commenced in January 2000 to evaluate ways of improving care for older people through action research. My interest in this project was linked to advancing the work undertaken on clinical supervision reported in the case study, and to focus in a more in-depth way on the development of my research and organisational consultancy skills. I joined a team of seven research and development nurses working in variety of NHS Trusts (acute, primary care, mental health). At each of the seven NHS Trust research sites, we worked to our NHS Trust's agenda to foster changes in gerontological clinical practice. The project was funded by the Central and East London Education Consortium (CELEC), which supported the principle of blurring the boundaries between education, practice and research in order to improve gerontological care. City University undertook the coordination, research and evaluation of the project over three years.

This report describes and evaluates changes from one of the research sites: a 50 bed nursing home which is part of an acute hospital NHS Trust. The focus of this collaborative and developmental project was to promote person-centred care within the continuing care facility. For ease of reference the NHS nursing home will be referred to as 'the Home' and all names used in this report are pseudonyms to provide anonymity. The concept of person-centred care is a broad one, but for the purposes of this report it is seen as an interpersonal process, taking place within a system of relationships, which affords dignity and respect of others. To strive towards achieving this goal, the project sought to improve psychosocial care and address depersonalisation, build staff morale, develop leadership, reduce organisational isolation and foster greater involvement of residents and family members in decisions about care.

Action research is new paradigm research, going beyond positivist views of describing social reality in a disinterested and neutral way (Meyer, 2001). This approach to research supports the notion that developing science and improving human welfare are best achieved through devising strategies in which research and actions are closely linked. This involves practitioners in the field identifying their practical concerns and exploring ways of addressing these issues within the complexities of the 'real world' (Coghlan & Brannick, 2001). Action research ensures research participants become active partners in

the research process to determine the direction and focus of the study as part of a collaborative enquiry.

This type of enquiry aspires to produce social knowledge that is practical and useful and as such is a form of education, personal development and social action. It involves learning from experience and is essentially a reflexive journey and as such requires this project to be written as a self-reflective account. For this reason the report is written in the first person. However, whilst acknowledging the subjective nature of this enquiry, I have endeavoured to write this account representing the experiences of the research participants who were instrumental in the process. During this project the Government published the NSF for Older People (Department of Health, 2001a) establishing person-centred care as a standard for all health and social services in the United Kingdom. In essence, this report describes 'how to' make steps towards achieving this standard.

The report is written up in such a way as to give enough contextual information to invite readers to judge the relevance of this research journey for themselves. It is therefore appropriate to set the research in context and to begin by telling the story. Action research does not take place in the controlled confines of a laboratory and relies on working with emergent themes and ideas from the field of study (Meyer, 2001). Telling the story seems the best way to illuminate the 'swampy lowlands' of everyday clinical practice (Schön, 1983).

4.1.2 Background to the Report

Four important background issues will be discussed in relation to this report: organisational issues leading to the funding of CARP and this project, the role of City University, the background literature and my own interests in taking up this action research role.

NHS organisational origins of CARP and this project

The decision by the Chief Nurses of CELEC to fund the seven research nurses for older people came about due to the difficulties in releasing nursing staff to take up educational activities offered by the University providers. This situation was largely attributed to acute nursing shortages within the NHS during the latter part of the 1990s with nursing vacancy rates of 15-30%[2] across CELEC. This serious situation demanded more creative ways of promoting educational opportunities for nurses. During this time there was much discussion and consultation concerning the NSF for Older People and a plethora of reports indicating that standards of nursing care for older people needed urgent attention and development (Health Advisory Service, 2000, 1998; Standing Nursing Midwifery Advisory Committee, 2001). Funding was made available via CELEC and local Universities were encouraged to tender for the co-ordination of the research nurses. The CARP proposal submitted by Professor Julienne Meyer at City University utilising action research was deemed most suitable by the Chief Nurses in light of the complexities of improving care for older people, working with the realities of staff shortages and NHS policy guidance.

The announcement of the funding for the research nurses led to a post allocated to each Trust in CELEC where older people received NHS care in September 1999. A post was established in an acute general NHS hospital, which is the focus of this research report. At this time in the local borough, mental health and community NHS services were being re-configured in line with the creation of Primary Care Groups (PCGs) as laid out in the White Paper *The New NHS Modern and Dependable* (Department of Health, 1997). As part of these changes the local general hospital took over the management of the continuing care facility (previously managed by the combined Mental Health and Community NHS Trust). This rather unorthodox service configuration of continuing care services within the acute Trust was driven by a desire to minimise delayed hospital discharges. An NHS continuing care facility had closed in the borough three years previously and subsequent delayed discharges from hospital had been very serious. The direct control of these continuing care beds was considered by senior managers as important in preventing delays. The transfer of the Home to the acute Trust occurred in October 1999, three

[2] Statistics from local workforce development department in 1999

months prior to the commencement of the project. The arrival of this 50 bed nursing home into the acute Trust was the trigger to establishing this project within this service. This was a managerial decision based upon concerns over the perceived poor reputation of the Home. The project took place in response to these organisational changes, borne out of wish to improve and develop practice at the Home now within a new organisation. In essence, the selection of the research site was a 'top down' process conceived by senior managers as part of the transfer arrangements of the nursing home. However, it was widely understood that the research nurse would work with participants at the Home in a collaborative way to secure their support for this project and to ensure the voluntary nature of their participation (further discussion of this negotiation process is found on page 114).

The role of City University

The successful tender by City University clearly bound all research nurses to promoting evidence based practice designed to improve and raise standards of care for older people. The CARP objectives were as follows:

1. To co-ordinate and facilitate seven research and development posts in a variety of health care settings, each with the central objective of promoting evidence based practice for nursing elderly patients.

2. To demonstrate evidence based practice linked to the NSF for Older People

3. To plan, implement and evaluate the process and outcomes of change in care for older people, using an action research approach.

4. To facilitate learning, cross fertilisation of ideas and partnerships between NHS Trusts through regular seminars and workshops

5. To provide academic support for the management of change

6. To provide a channel for information flowing between experts and practitioners

7. To provide collective evaluation of CARP and disseminate findings both locally and nationally

City University coordinated the action research activities and supported learning, cross-fertilisation of ideas and partnership working with the seven NHS Trusts. A project steering group at City University, with senior manager representation from each of the NHS Trusts and from the Educational Consortium, met every 8 – 12 weeks to guide and review the overall project's development. In addition, the role of the University served to establish both local and national networks e.g. meetings with the Nurse Advisor for Older People at the Department of Health. This provided opportunities to feedback on the issues of putting policy into practice.

Under the guidance of the Project Co-ordinator, the researchers met together once per week to share ideas, learn skills and review progress. A needs-led educational programme was established for the research team e.g. an interviewing skills workshop, and training in the usage of audit tools. Further, to support the change process a monthly action learning set to foster learning from practice was established for the researchers. This was facilitated by the project co-ordinator. Individual academic supervision of action research activities was also provided through regular meetings with an academic supervisor. Annual appraisal of the researcher's performance was undertaken in collaboration with the academic supervisor and senior manager within the NHS Trust. The co-ordinating role of City University for the researchers created a forum for development, support, collaboration and learning. The opportunities to work with a team of researchers within a framework of support and development offered by the University e.g. action learning and the flexibility of a needs-led programme, created extensive opportunities for both personal and professional development.

Background gerontological literature

England is an ageing society, with the number of older people set to increase (Department of Health, 2001a). In turn, older people are a significant proportion of direct and potential users of health and social services in the statutory, voluntary and private sectors, with those over 65 years currently occupying two thirds of all hospital beds (Department of Health, 2001c). However, there is evidence that older people as a group experience considerable social and economic inequality compared with the rest of the population, particularly in London (Howse & Prophet, 2000). Furthermore, there are concerns about the quality of health and social care received by older people (HAS 2000,

1998; SNMAC, 2001). This led to the NSF for Older People being established to drive up standards and reduce unacceptable variations in health and social care (Department of Health, 2001a). The NSF sets standards concerned with rooting out age discrimination, providing person-centred care, promoting older people's health and independence and fitting services around people's needs.

Drawing upon the literature reviewed on person-centred care in an earlier chapter, the approach to person-centred care in the NSF for Older People has been critiqued as being overly individualistic and consumerist (see page 58 for more detail), and as such may not best suit the needs of dependent, vulnerable, frail older people. It was argued that the policy perspective on person-centred care is too narrow and inadequately addresses the major influence of Rogerian humanistic psychology (see page 52 for further detail). The Rogerian idea influencing person-centred care is based upon the innate human actualising tendency towards growth and development has been widely applied within nursing and across the helping professions (Binnie & Titchen, 1999; Kirschenbaum & Land Henderson, 1990). The application of Rogerian ideas within gerontological care is best illustrated in the work of Tom Kitwood's person-centred approaches to people living with dementia (Kitwood, 1997). More recently, Nolan et al. (2004) advocate a more interdependent framework as devised by the Tresolini and Pew-Fetzer, (1994) in which the nature of relationships within healthcare are seen as the major determinants of quality of care. The Task Force stated:

> "The patient-centred model, while promoting a more whole person approach, does not explicitly embrace the community and interdisciplinary aspects of health care that are of such importance today. The phrase relationship-centred care captures the importance of interaction among people as the foundation of any therapeutic or healing activity." (Tresolini & Pew-Fetzer Task Force, 1994; 11)

The Task Force identifies three important dimensions of relationship centred care:

- The patient/resident - practitioner relationship
- The community - practitioner relationship

- Practitioner - practitioner relationship

These three psychosocial dimensions of relationship centred care bring to the fore inter-professional working, and community relationships, as well as the individual relationships with clients and offer a broader and more systemic way of viewing 'the person' within gerontological care.

Drawing upon the key messages from the analysis of the person-centred literature undertaken in the earlier chapter, it is possible to say that person-centred care, whilst conceptually rich, has limited empirical evidence to support implementation in practice (Dewing, 2004; McCormack, 2004; Nolan et al., 2004). Indeed Williams et al., (1999) identify serious blocks in the full realisation of this approach and argue these have been inadequately explicated in the literature i.e. the 'how to' literature needs to be urgently addressed. This project sought to address this situation. The evidence base around person-centred care is generally small-scale descriptive research. Concerns have been raised by Williams and Grant (1998) and Woods (2001) as to the appropriateness of large randomised controlled trials to evaluate the efficacy of person-centred approaches. These authors argue that methodologically small-scale descriptive research is the most appropriate for the evaluation of person-centred approaches. In addition the challenges of implementing a conceptual idea into practice i.e. 'walking the talk' rather than 'just talking the walk' make action research a particularly suitable methodology due to the emphasis on social action and learning from the process of change (Perrin, 1997a).

The most extensive evaluation of person-centred care has taken place in dementia care as 74% (n = 78) of the literature reviewed on person-centred care involved people with dementia (see page 66 for further detail). Most research evidence is associated with Dementia Care Mapping and this powerful tool has been subjected to extensive testing and evaluation. The tool is both quantitative and qualitative in design and has a proven track record in improving the quality of person-centred care when part of an organisational quality assurance programme (Brooker et al., 1998). However, the evidence to support the broader application of person-centred approaches outside of dementia care is extremely limited. This indicates a current gap in knowledge, with minimal evidence available evaluating the application of person-centred approaches beyond

dementia care. An evaluation of the development of person-centred care in a generic long-term care facility outside of the speciality of dementia care was warranted.

The application of person-centred approaches is diverse and from a review of the literature six areas emerged in which person-centred ideas were being tried and tested. These were:

1. Quality of communication and relationships with older people and their families/informal carers to develop person-centred care

2. Development of person-centred care through audit, standard setting and benchmarking

3. Occupational activities and person-centred care

4. Biographical approaches to person- centred care

5. Staff development to support person-centred care

6. Organisational/service evaluation of person-centred approaches

The literature reviewed indicated a paucity of research evidence on the necessary skills, knowledge and attitudes of staff required in the delivery person-centred approaches. From a total of 105 papers reviewed, the fewest number of research based articles was found in this area (5 papers). This does seem somewhat paradoxical when Kitwood (1997) so clearly perceives the quality of person-centred care as being largely determined by the self-awareness and skills of carers. The project sought to address this gap in the knowledge concerned with staff development needs to support the delivery of person-centred care.

To conclude, from an extensive review of the person-centred literature (see earlier chapter), gaps in the body of knowledge were found in 'how to' apply this concept in clinical practice, the application of this approach outside of dementia care and in particular the staff development needs in this field. These areas of practice development were addressed in this action research project.

Background of the researcher

I undertook a nursing degree programme at Sheffield Polytechnic from 1983-1987 and a particular experience whilst a first year student warrants explanation, as it was a powerful influence behind my taking up the project. My first year student nurse placements took place in elderly care wards. During my second placement in the summer of 1984, I was involved in witnessing staff drawing up tea and porridge in a 50 millilitre syringe and 'feeding' patients who were tipped back in Buxton chairs. The patients being fed in this way coughed, struggled, resisted and appeared very distressed. This occurred in a ward that smelled of urine, where patients were often toileted without clothes (covered only in a drawsheet) and in an environment that seemed unfriendly, harsh and cruel. With the support of extremely dedicated nurse teachers at the Polytechnic I made a written complaint concerning the feeding of patients. This led to an investigation of care on the ward and two years later I was invited by the senior nurse of the service to return and see the changes made in relation to quality of care. The smell of urine had disappeared, each patient was wearing their own clothes, the ward was bright and most importantly patients looked relaxed and comfortable. Nursing care had improved and I was amazed.

My first staff nurse post was at the same hospital in a long-stay ward for the chronically ill. The closure of the hospital resulted in my moving on to work in an intensive care unit. Whilst working on the ICU, I applied for a Rotary International Scholarship and was successful in securing a place on a Masters programme in nursing in the USA from 1988-1990. In the US, I was shocked to find the usage of physical restraint and undertook my dissertation on the prevalence of physical restraint on post-operative elderly patients in a large US hospital. I observed 264 elderly post-operative patients over a two month period and found that the overall incidence of physical restraint was 10% and rates increased to 25% in critical care areas (Ashburner, 1990). This research supported the local development of a 'sitter service' to offer an alternative to the usage of physical restraint. I returned to the England in early 1991.

I worked in a large central London hospital and progressed to work as a staff development nurse in a large cardiac department. This teaching post built skills in developing others and gave me expertise in education and training. I applied for a full-time PhD studentship in 1995 at City University. I was the first doctoral student in the

School of Nursing and Midwifery, but felt isolated in this role. I had just started collecting data in a local hospital and whilst 'in the field' was encouraged to apply for a vacant post as Senior Nurse for Education, Practice Development and Research. I worked in this role for three years and in this time completed a Masters in psychoanalytic approaches to organisational consultancy at the Tavistock Clinic. It was during this time I established a system of clinical supervision as described in the case study. My interest in psychodynamics led me to join a psychotherapy group and my membership of this group has continued throughout this project. This served as an important place for self-reflection and developing my group work and facilitation skills.

The main frustration of the senior nurse post was feeling 'squeezed' in terms of research activities, with managerial activities taking precedent. I wanted a role that could develop my consultancy skills, build on organisational change and make research the priority. The funding for the CARP research nurse posts was providential and I successfully applied for the post advertised in the hospital where I had worked for over three years. The focus of the study in the nursing home was daunting but I was encouraged by the extensive support offered by the University, the opportunities to work in a team of researchers and the recruitment of a new dynamic Modern Matron to lead elderly services at the hospital. All these factors felt positive in the face of what was perceived to be a 'failing' nursing home with poor standards of care. At this stage I felt that if I could help staff make changes in this bleak environment, then this would be a real achievement and give me a sense of competence and resilience in supporting the change process. I took up post in January 2000 but for the first year worked part-time (2.5 days per week) in the research role. The other days allowed me to complete the local facilitation of the RCN clinical leadership programme. This programme was also underpinned by action research and supported the development of my facilitation skills.

I hope this gives the reader adequate information relating to the background of the project, in particular the organisational influences, the relevant literature and my motivation for engaging with the project. My interest in psychodynamics is associated with a positive and optimistic outlook and I brought these values to this project. The following section describes the profile of the nursing home and the developmental stages of the project.

4.1.3 Profile of the nursing home

The Home was a purpose built facility, which opened in 1995. Both staff and residents were re-located to the new home from long stay geriatric wards. Residents living in the home were aged over 65 years, and were highly dependent with chronic and enduring illnesses. Immobility, incontinence, feeding and swallowing difficulties and cognitive impairment were the main determinants of admission into the home. Nearly all people permanently living in the nursing home die in residence with an average length of stay in the Home of 2.2 years. There are 50 beds for local borough residents who meet NHS continuing care criteria. Within this service is a 5-bed respite care service. Terry (1997) argues that the spectres of deterioration and death are subsumed in the innocuous words of 'continuing care'.

The local community

The local borough was economically deprived with consequent poor health. In 2000, the borough rated 17th out of 354 local authorities (England and Wales) in terms of income deprived individuals. Life expectancy in the borough was 73.2 years for men and 79.7 for women. For males, this ranks the borough 322 out of 352 for life expectancy amongst local authorities in England and Wales, whilst for females it was better at 250 out of 352. The gap between the borough and the population as a whole in England for life expectancy was 2 years for men and 0.4 years for women[3].

The borough is ethnically diverse with an estimated 38% of the borough population being from minority ethnic groups. The single largest minority group is black Caribbean (11%), with black African (8.8%) the second largest minority group. One in five people aged over 65 years belong to a minority ethnic group, with estimates that by 2010; this will increase to approximately 30%. The white population will be the only population to decrease overall in the borough, with an estimated decrease of 15% for those aged 65-74 years[4].

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[3] Source: All information drawn from the Local Borough Health Improvement and Modernisation Programme: 2002-2005 (not directly referenced to protect anonymity)

[4] Source: Borough Joint Investment Plan 2001 (not directly referenced to protect anonymity)

The physical environment of the nursing home

The nursing home, although modern, is located in the grounds of an old Victorian hospital, the current headquarters for the Primary Care Trust (PCT). Despite proximity to the PCT, the Home was managed by the local acute NHS Trust approximately three miles away. The first two floors of the building housed the nursing home with the remaining three floors used for social housing run by a local housing association. On occasion problems arose from noise, littering and floods from bathrooms above the nursing home.

Every resident in the Home had his/her own room provided, with a wash-basin, bed and built-in wardrobe. All rooms had en-suite toilet facilities but for the majority of residents these facilities were shared with an adjacent room. Every room had a phone point and wall light over the bed. The floors were each divided into three corridors and all the corridors had a bathroom although no shower facilities were available. There were two lounges for residents on each floor. On the first floor there was a laundry room, with an industrial washer and clothes dryer. The original design of the home was based upon 'upstairs and downstairs' model with larger lounges and communal facilities on the ground floor. This model of living whereby residents came down onto the ground floor during the day had proved extremely difficult for nursing staff and was no longer practiced. Nurses described expending large amounts of energy 'running up and down the stairs' between floors and of the difficulties in monitoring residents who wished or were unable to come downstairs. Staff reported having no influence in the original design of the home and complained that there were many poor design features e.g. a call bell system that only alerted nurses through a display box on the ground floor. Various design problems had not been addressed despite the facility having been open for over five years.

There were five exit points to the building on the ground floor, which made security of the building difficult. Of particular concern were two fire exits and the site of the main entrance directly onto a busy road. Nurses considered this highly unsuitable for wandering residents with unsteady gait. On both floors there was a small room used for medicines and there were six small sluice areas. At the commencement of the project, there was no nursing office on the top floor of the nursing home or designated teaching

room for staff training activities. The residents' activities room served as a smoking room with no provision for non-smokers. One resident complained of the noise from the road and in particular from the large heavy trucks which used the road as a 'short cut' onto a nearby major road.

There were two dining rooms on each floor and a kitchen for the preparation, storage and re-constitution of food (a cook-chill system was utilised), as well as five smaller kitchens in the nursing home. However, tea and coffee making facilities were not formally available for visitors and family members. Staff facilities include changing rooms and a staff room. Residents and staff did have access to a garden but the lack of garden furniture did not promote its usage.

The workforce

A nursing home manager plus a team leader led 47 nursing staff, of which 17 were registered nurses and 30 were unregistered nurses. At the start of the project some domestic activities were undertaken by the nurses (washing up and laundry) with an 'out-sourced' cleaning service who were contracted to provide three staff to clean in the morning and two staff in the evening. Food was prepared off-site but a domestic supervisor prepared the cook-chill meals for residents. In addition, there was an 'odd job' man and a full-time administrator.

Therapy input at the home was minimal, with no social work, speech and language therapy, psychology, chiropody or occupational therapy services routinely available. There was a part-time activities co-ordinator who had no line manager to support or supervise her work. The only formal therapy input was via the dietetic department for the management of tube feeds and a physiotherapy session two afternoons per week. However, the nurses reported satisfaction with the medical care provided to the nursing home via local general practitioners and a bi-weekly session provided by the hospital consultant in medicine for older people.

In 1997 and 1998 a total of 15 nursing staff were re-deployed to the nursing home in the light of the reduction of NHS continuing care beds and the closure of a local NHS nursing home. This meant that approximately a third of all staff had not originally chosen to work in this nursing home.

During the first year there was a vacancy rate of 17% (8 health care assistant posts unfilled) with a high corresponding agency nurse usage (£208,906 spent from April 2000 - March 2001). However, staff turnover was not high. On average, one or two registered nurses and approximately three or four unregistered staff left per year. The length of service in the NHS for 16 staff members was greater than 20 years. It was estimated that a substantial group (45%) of staff would retire over the next five years. At the beginning of the project, annual staff sickness was high with 7% of working days lost (see page 239 for analysis of staff sickness, turnover and agency nurse usage over the study period).

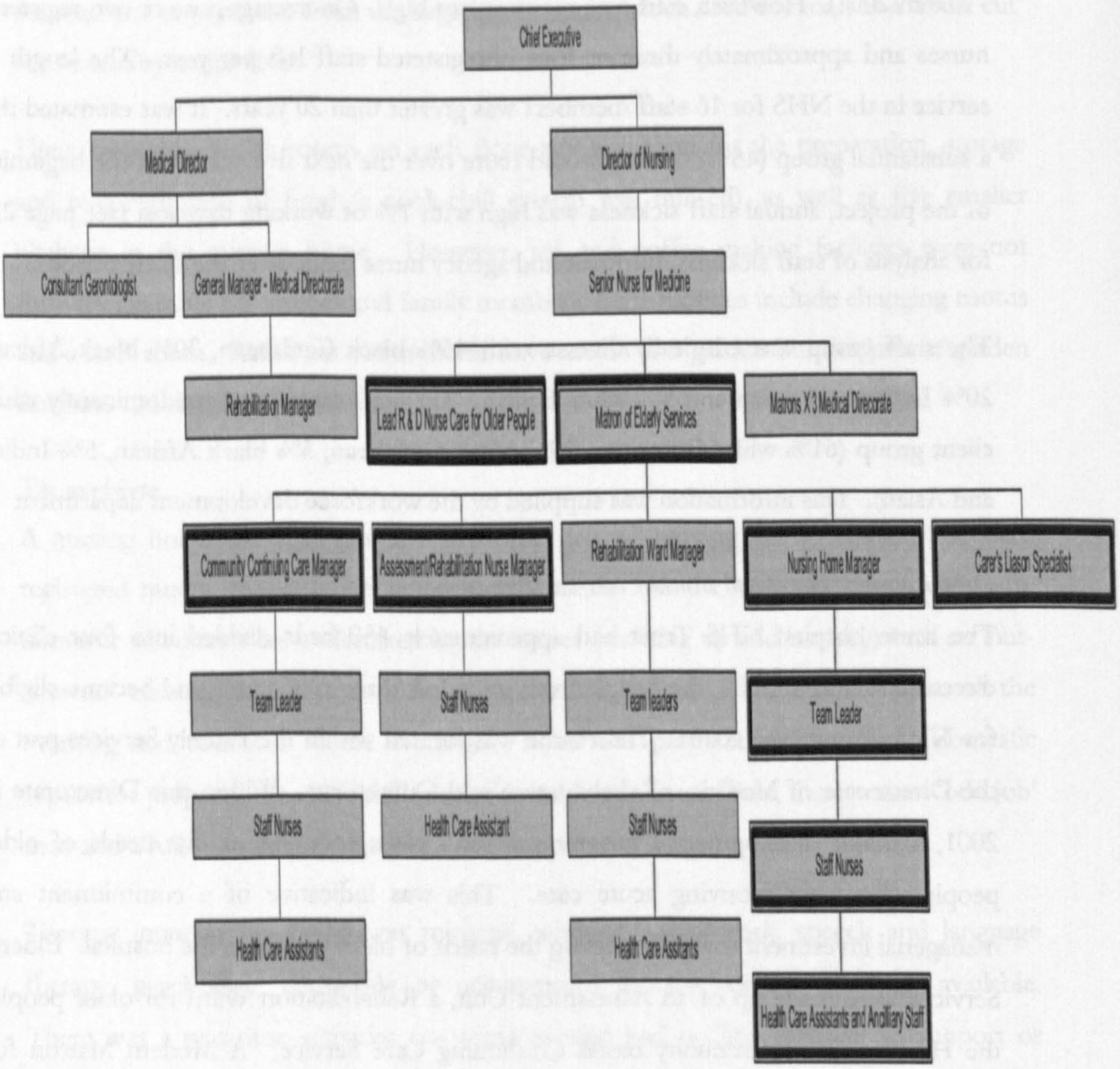
The staff group was ethnically diverse with 45% black Caribbean, 30% black African, 20% Indian and Asian and 5% white British. The staff cared for a predominantly white client group (61% white European, 29% black Caribbean, 5% black African, 5% Indian and Asian). This information was supplied by the workforce development department

Organisational context and structure over the study period

The acute hospital NHS Trust had approximately 450 beds divided into four clinical directorates and in 2002, the hospital was awarded 'three star' status and became eligible for NHS Foundation status. The Home was located within the Elderly Services part of the Directorate of Medicine, Rehabilitation and Outpatients. Within this Directorate in 2001, a major developmental programme took place focusing on the needs of older people who were receiving acute care. This was indicative of a commitment and managerial investment towards meeting the needs of older people in the hospital. Elderly Services were made up of an Assessment Unit, a Rehabilitation Ward for older people, the Home and a Community based Continuing Care Service. A Modern Matron for Elderly Services managed these services.

The following chart shows the organisational structure in place for the greater part of the project (the boxes highlighted indicate staff with the greatest involvement in the project).

Diagram 1: Organisational structure in place for the greater part of the action research project developing person-centred care.



4.1.4 Stages of the project - the story

The story of the research project is told to allow the reader to get an overall feel of the emergent issues and 'see the project in the round'. This story is told as a narrative account of my research journey but whenever possible I will try to present the views of others involved in the project.

4.1.5 The transfer: October 1999 - January 2001

The management transfer of the Home into the acute NHS Trust occurred during this period. This phase preceded the commencement of the project in January 2000, but was influential in the subsequent evolution of this work. The transfer of the nursing home was a time of significant change and naturally staff anxieties were high. From my perspective there were two important developments that took place during this period. The first event involved a managerial report written by a Senior Nurse for Medicine from the acute hospital evaluating the Home and identifying the problems and issues to be addressed. The staff viewed this report as damning; they felt poorly understood, undermined and inadequately consulted. This report seemed to create an environment in the Home in which 'the battle lines' were drawn. Staff at the Home entrenched to defensive position to fend off 'the attacks' from the external management.

The other important development during this time concerned my action research role in the Home. This appeared to be presented as a *'fait accompli'* in which the participants were told that I would be part of the new organisational structure on transfer to the acute NHS Trust. There was a managerial assumption that this role was positive and an additional bonus to the service. Indeed the action research post was described by senior managers as a 'luxury item'. In adopting this stance, it placed the Home Manager and staff in a difficult position, as the 'luxury' of an action researcher could not be turned down or rejected without appearing extremely ungrateful.

These two issues contributed to the complex backdrop of the project and made for a difficult start. An added complexity was my previous managerial role in the acute hospital as the Senior Nurse for Education, Practice Development and Research. Although not a role directly associated with the management of a service, I had previously been a colleague and peer of the Senior Nurse who had written the managerial report on the Home and thereby I represented 'management' by association. In addition, I shared an office with the Matron of Elderly Services. I was consequently viewed by participants in the study as being 'on the side' of managers. All these factors led to a difficult and inauspicious start to the project.

4.1.6 Consultation: January 2000 - March 2001

This period involved trying to build relationships with staff, residents and family members. The purpose of this period was to work collaboratively with all participants to identify the future development of the project and agree the project research proposal. Activities during this period included my working clinical shifts, attending formal and informal meetings, meeting relatives and residents, reviewing documentation and educational activities. Part of the consultation process involved collecting audit data with staff and working to consider the implications and future actions in relation to audit findings. The two audit tools used were a quality interaction tool (QUIS) (Dean, Proudfoot, & Lindesay, 1993) evaluating interpersonal communication and a nursing quality assessment tool (Nursing Home Monitor II) (Morton et al., 1991). The selection of these audit tools was determined by the CARP researchers and undertaken across all seven CARP research sites (for further discussion of these tools see page 150). Data collected were recorded in field notes kept confidentially by me. Findings from audit activities were circulated to all staff for comment and finally the action research proposal was worked up for comment and staff feedback in December 2000.

Building relationships during this period was not easy. My presence appeared to be tolerated by staff but I was treated with a great deal of suspicion. On the whole I felt a silent resistance to my presence. It would be unrealistic to expect no suspicion and indeed a degree of healthy cynicism is to be expected at the start of a project of this nature. However, my impression of this phase was that the anxieties of staff about me were largely uncontained by the Manager of the Home resulting, in a defensive and resentful staff mentality. Additionally, family members and residents raised concerns over smells of incontinence, the dirty environment, unfriendly staff and poor management. Equally, staff reported low morale, conflicts between registered and unregistered nurses, unfriendly and difficult visitors, poor equipment and a dirty environment. There was certainly scope for improvement.

My field notes from this period are filled with desperation and despair. I would dread making visits to the Home. I described feeling as if I was entering a ghetto, isolated and cut off from the outside world in which outsiders were viewed as a threat. The alignment of the nursing home to a ghetto in my mind represented the ethnicity profile of largely

black staff group caring for a heavily dependent, vulnerable, frail group of elderly people. In essence, both groups were working against societal pressures of racism and ageism with subsequent risks of low expectations, marginalisation and oppression. In addition, the Home seemed cut off from the NHS and indeed had faced the threat of privatisation in 1998. This institution had the feeling of being 'unwanted' by the NHS and had seemingly adopted a survival strategy of blocking out the outside world. This was typified by the door entry system to the Home, in which I would frequently wait up to 10 – 15 minutes trying to enter the building. I felt this important boundary represented the 'closed' nature of this institution and symbolised the desire to keep 'outsiders' at bay.

During this period an issue relating to both verbal and physical abuse of a resident by an agency nurse was witnessed by the Manager of the Home and reported in July 2000. In response to this, I was invited to provide educational input for staff on elder abuse. Twelve two-hour workshops took place and proved to be useful in opening up debates on how staff felt psychologically abused by family members and their vulnerabilities over residents' screaming which could easily be misconstrued. These workshops started to build a more open dialogue between me and the staff.

Audit results showed poor quality of interactions (QUIS findings) with substantial scope for improvement in the quality of care (Nursing Home Monitor II). For detailed audit findings see page 180. Social care was particularly weak emphasising the strong orientation to physical care. Eight sessions were held with staff to present the audit findings. These sessions were kept as interactive as possible and involvement of staff was high. The findings relating to QUIS seemed more easily understood whilst the audit findings of Nursing Home Monitor II were difficult to make interesting and appeared to bore staff.

At the end of the consultation period, the research proposal was written and circulated to the staff for debate at four subsequent staff meetings. Few staff commented and perhaps unsurprisingly, I was met with a largely indifferent response. The support I received outside the Home kept me going during this period. The regular action learning meetings established at the University were very helpful, with guidance from research peers, the project co-ordinator and project director vitally important. In addition, the collegial

relationship established with the Matron of Elderly Services within the NHS Trust started to blossom. We both wanted to build and develop this relationship but were concerned that managerial pressures e.g. balancing budgets, may be at odds with the developmental ethos and values of the project. In order to explore these potential difficulties, monthly meetings were established to explore the interface between research and managerial agendas. These meetings were facilitated by an external organisational consultant and psychotherapist. These extensive systems of support helped me to contain my anxieties about this work and kept me going in the face of what felt to be insurmountable difficulties in the Home.

4.1.7 Action Cycles: April 2001-December 2002

Central to action research are the activities of planning, acting, observing, reflecting and re-planning through action cycles (Coghlan & Brannick, 2001). The action cycles in this project did not occur simultaneously and emerged in an organic way with some cycles having substantially more impact than others. This 21 month phase saw the project 'get into gear' and establish very different relationships with staff, residents and family members. For the first year, changes were slow, and resentment and anger about my presence in the Home was not openly verbalised but seemed ever present. After one year I was exhausted and decided to take one month away from the Home to get some perspective on the situation. During my absence, anger and resentment surfaced and the mouthpiece for these feelings was the Manager of the Home. She was able to say to senior managers that my presence in the Home was undermining and how much she resented the project. She felt changes were happening too fast without adequate consultation. From semi-structured interview data collected (at the close of the project) the Manager of the Home described negative past experiences:

"In the past we have had a lot of negative feedback from people coming in from the outside including research and being used derogatively. I had a lot of hang ups to tell you the honest truth. We had been knocked about and people saw you taking my job, I was approached by staff who said who is Charlotte, is she taking over your job? It was a time of transition and we did not know if we would lose our jobs, it was into

the unknown.....Despite the problems, I knew things needed to change, I wanted it to change but it was difficult, I did things half heartedly and I was working with managers who I saw as the enemy, I did not know them." (Staff interview 1.2)

The surfacing of these negative feelings (described in the quotation below by a staff member as the flash point) was a major step forward and with a senior manager as arbitrator, the manager and I were able to meet and work together on the way forward. Interestingly, the structure and activities of the project remained the same and the subsequent pace of change accelerated, but I was finally allowed to be part of the Home as opposed to an unwelcome visitor. Equally the manager of the Home was able to feel the project belonged to her and her team. Importantly, senior management acknowledged that they had not been adequately involved and subsequently had a much stronger presence in the Home. A senior manager reflected on the managerial involvement within the project and stated during an semi-structured exit interview in September 2002:

"I think we should have been more involved. We could have managed the process better at the start but we did manage to rescue it. We had the crisis point and I think that was because we did not really negotiate the project – it was an 'add on'. There was a lot of baggage, and I think they'd been abused for years and we really had to prove ourselves to the staff. But I am not sure, I do think no matter how we started it, it would have been very difficult because of all the mistrust. The shame is it took so long. I suspect if we had done a better negotiation we would be in the same place as we are. The flash point did work well." (Staff interview 1.0)

The second year of this phase saw substantial improvements and real progress was made in the context of greatly improved relationships at all levels within the Home particularly between myself and the Manager of the Home. The ensuing discussion will present the six action cycles undertaken during this phase of the project. However, it must be emphasised that greatest progress in all the action cycles occurred during 2002 after the negative and difficult feelings were surfaced and the subsequent stronger senior managerial presence in the Home.

4.1.7.1 Cycle 1: Biographical interviews

The cycle emerged as staff acknowledged the physical focus of care and the low scores of social care identified in the Nursing Home Monitor II audit (see page 183 for further details). Staff reported that even if residents lived in the home over a long period they often knew very little about the resident's previous life. They also reported wanting to improve relationships with relatives and in the light of all these issues were willing to try and develop more biographical approaches to care.

Twenty-one biographical interviews were undertaken with residents, usually with family members present. Nineteen interviews took place with a staff member and myself and the remaining interviews were carried out by staff independently. The biographical interviews took on average two hours per interview, depending on the need for periods of rest whilst recounting information. The process of each interview involved a staff member identifying a resident within their team whom they would like to know better. I would meet with the staff member to facilitate the process and together we would identify the questions the staff member would like to ask, think about the process and agree a way forward. The staff member would then invite the resident to participate and, if appropriate, contact a family member to be involved. Consent was obtained and an interview date and time established. My presence in the interview was to record information, act as a resource, and mentor the nurse through the process. Each session was followed by a debriefing session with the nurse on her experience and to review how best to share that experience and information within a team supervision session. I wrote up the biographical information as a booklet and gave this to the nurse who then checked with the resident and/or family member if the information was accurate and secured their final agreement for the information to be shared more widely. This work was intimate and required sensitivity but was extremely powerful in building relationships between myself, the nurse, the resident and family member. My psychodynamic training and experiences in psychotherapy were helpful in facilitating this process and dealing with complex and frequently emotionally charged material. All grades of staff participated in these activities but required intensive support in interviewing skills and developing greater sensitivity to the issues often presented e.g. abusive family relationships, the loss of a child, a difficult divorce or child born to a different partner.

The outcomes of this cycle were numerous but in the main related to improved relationships between the resident, family and staff member. At the close of the project a formal "Getting to Know You" booklet was developed to support ongoing biographical work. This work was instrumental in changing relationships between various groups and seemed to contribute to creating a more relaxed and comfortable atmosphere within the Home. A staff nurse during a semi-structured interview reported the impact of undertaking a resident's life history:

> "I am now more aware of challenging behaviours and if people think she *(the resident*)* is being spiteful and putting on, you know that you have more understanding about that person and it helps you understand her better. (Staff interview." 2.2) (*my addition)

An unregistered staff member stated the positives of the process but also commented on the sadness associated with many of the life stories:

> "It was good and it sort of brings a closeness, and if you learn more about them then you know what they need. It did help with Bob and you can have laugh and a chat, but for many people his situation is like the worst nightmare coming true. We have to share that emotional aspect.....It feels bad bringing things like this to the surface and you are looking to that part of the future which is just about bringing sadness." (Staff interview 3.7)

It also became apparent in collecting residents' life stories that staff too may benefit from the opportunity to tell their life stories. The sharing of staff life stories took place at a staff induction day held within the Home with six new staff members, of whom five subsequently undertook biographical interviews with residents. However, sharing staff life stories through induction floundered as an activity and did not become part of 'normal practice' with staff induction remaining a largely 'checklist' activity.

4.1.7.2 Cycle 2: clinical supervision

There were no systems in place for staff to reflect systematically on the experience of caring for the residents. In addition, the staff reported difficulties with team working, in particular tensions between registered and non-registered nurses. Group supervision for

each nursing team was offered to staff to provide an arena in which team-working issues could be explored. In addition, giving staff the opportunity to set the agenda in clinical supervision sessions modelled a person-centred approach to interactions and relationships.

A substantial proportion of staff (45%) had over 20 years experience in the NHS and were experienced practitioners. The experiential approach to learning offered through clinical supervision provided a mechanism for exploring and sharing the learning gained through many years of NHS service. An experimental study by Berg, Hansson and Hallberg (1994) found that after one year of group clinical supervision for nurses caring for patients with severe dementia, levels of creativity significantly increased whilst levels of tedium and burnout decreased. The control group over the study period experienced no changes. This small scale but well designed study indicated the potential benefits of clinical supervision in a similar field of nursing. Clinical supervision offered a potential vehicle to sustain and develop the nurses, 16 of which had over 20 years NHS experience.

One hundred and four weekly sessions took place in total. Sessions took place for one hour at 14.00 – 15.00 on Mondays for the staff team working on the first floor and Tuesdays at the same time for the staff team on the ground floor. Meetings took place in a consistent location on each floor. Following more psychodynamically informed group management practices, the group boundaries of time, location and frequency were rigidly upheld in order to try and establish a containing emotional space for group members (Terry 1997). Attendance at sessions varied between 4 – 12 members but was not consistent due to nursing shift patterns. Ground rules were established for each group and were given to all new staff that attended sessions. The purpose of the groups was to create a regular forum in which staff could discuss work related experiences and share biographical information collected during the interviews described in cycle one.

Each session started with a 5 – 10 minute review and 'catch up' on the previous session. Once the group were ready to move on the session opened up to discuss issues raised by the members present. At the close, actions (if any) were agreed and were then presented for feedback at the opening of the following group. Through this group structure,

cyclical patterns of planning, action and reflection were established with staff. This resulted in supervision sessions becoming 'the backbone' of this action research project.

The outcomes stemming from issues raised in supervision were diverse. Examples included a letter written to the manager by supervision group members raising concerns about the quality of food and in particular serving food cold. This resulted in a change in the timing of serving of meals and additional food warmer trolleys were provided. Another example included a presentation of a resident's biography by a staff nurse which prompted a discussion on a previous allegation of physical abuse made by this resident against an unidentified staff member. This then allowed staff to describe their experiences of feeling sexually abused by this resident. The staff felt that they just 'had to put up with this situation'. This then led to a meeting with the resident, managers and staff to review his behaviour. Incidents regarding his sexually inappropriate behaviour were recorded and subsequently decreased over time as staff were better able to challenge the behaviour.

The outcomes of this cycle were far reaching in terms of improved relationships and staff feeling more confident in their practice. Staff described feeling heard and perhaps for the first time acknowledging they had something important to contribute to the quality of care. An unregistered nurse stated in an interview:

> "it opened up your eyes to more of what you are actually doing and appreciate what you are doing. When you talk to us you realise what we are doing in our work and that we are someone as well." (Staff interview 3.5)

These sessions allowed me to be come part of the fabric of the institution and I believe over time I became a respected and valued member of the team. This reciprocated the respect I afforded to staff often struggling with difficult and challenging issues presented in sessions.

4.1.7.3 Cycle 3: action learning

Leadership development opportunities had not been available to the manager of the nursing home prior to the commencement of the project. The pivotal role of effective leadership within nursing homes is clearly identified in a study to determine the

characteristics of well managed and poorly managed nursing homes (Chambers & Tyrer, 2002). My previous positive experience in facilitating leadership development for nurses within the hospital certainly influenced this action cycle. In addition, policy recommendations advocated the strengthening of nursing leadership (Department of Health 1999a) and clinical leadership development has been recognised as a key factor in supporting the implementation of the NSF for Older People (Department of Health, 2003).

The purpose of action research is to foster and develop change. However, Revans (1983) suggests that organisations, and in particular managers within them, cannot flourish unless their rate of learning (L) is greater (or equal to) the rate of change (C) being experienced. For organisations (and people) to flourish through change it was hypothesised that: $L \geq C$. Revans (1983) and subsequent authors including Brockbank and McGill (1998) advocate action learning as a way for managers to achieve this. Therefore, action learning was adopted as a mechanism to support learning for the manager of the nursing home in the face of change.

The nursing home was off-site to the main hospital and at risk of being isolated. Networks, systems and relationships to the hospital were new. An action learning set for managers within elderly services could share and build networks, relationships, integration and understanding of the new organisation. A CARP research colleague undertaking her work within older people's services in the local Mental Health NHS Trust was interested in working jointly to establish an action learning set for managers. This created an opportunity for managers from a wide range of services for older people to work together on issues. It opened up the possibility of sharing learning across the spectrum of mental health and general gerontological care.

The time parameters around this cycle were over a period of 27 months and included 27 monthly action learning sets starting in January 2001 and completing in March 2003. Eight managers participated over this period (three managers from the acute Trust and five managers from the mental health Trust) with the set size no larger than seven members at any one time. Set meetings took place over a day allowing an opportunity for each set member to have 45 – 60 minutes of 'air time' to present an issue they wished to

reflect upon. The set developed into a cohesive and constructive group, which I enjoyed co-facilitating with my CARP research colleague. The structure of each set member's 'air time' started with an up-date from the previous meeting and feedback on action points, followed by an issue of the presenter's choice and an agreement of action points at the close of the time allocated. This process was repeated for each set member wishing to use the group.

The process of action learning i.e. of presenting an issue, reflecting, agreeing actions, implementing and reflecting on those actions, ran in parallel with the team supervision sessions, and also supported the reflective cycles underpinning the action research process. The positive 'spin offs' of participating in this action learning set for the manager of the Home were clearly identified through annual evaluations of learning by set members. Initially she identified being extremely fearful of the process, but over time reported developing her leadership skills, not getting lost in problems, better performance management of her teams and described the power of the process in the following way:

> "Given me a new perspective on life. It has been a very positive challenge. Professionally, I feel as if I have grown up." (ALS evaluation 2)

4.1.7.4 Cycle 4: A carers' group

A group mainly consisting of family members had been previously established in the Home but had ceased running in 1997. Previous attempts via written invitation to establish a users' and carers' group in 2000 had generated little interest with only one family member showing any interest. A group of staff spoke favourably of a carers' group established in another local nursing home where they had previously been employed. Managers were also keen to re-establish a carers' group. This stance was supported by policy initiatives encouraging greater representation and involvement of patients in the NHS (Department of Health, 1999b; Department of Health, 2000; Department of Health, 2001a).

The first meeting of the carers group took place in November 2001 with four subsequent meetings. Fifty-six relatives and residents attended the meetings with between 6-12 members attending each meeting. The group became known as the 'Friends of the Nursing Home' and was chaired by a family member. There was always a representative

from management at the meeting to answer queries and agree actions to be taken forward.

A wide range of activities developed out of this group including a regular chiropody service, increased therapy input from the physiotherapist, social activities including a barbeque, improvements in food quality e.g. full English breakfast option, and collaboration in research activities in designing an interview schedule and recommending interviews with family members, residents and staff. A report was written concerning the findings and presented to the Trust Hospital Board in November 2002. This was an extremely successful group and the commitment and enthusiasm from families was a positive force for change in this project. This was due to an increasing openness to feedback in the Home due largely to the greater involvement and leadership of the Home Manager.

4.1.7.5 Cycle 5: dementia care mapping to evaluate person-centred care

At the close of the consultation period the agreed aim of this project was the development of person-centred care. The most reliable and valid tool for the measurement of person-centred care is DCM (see literature review page 73 for further discussion). Learning how to use this tool, undertaking the audit and responding to the findings were seen as an action cycle part of the action research process.

The high prevalence of physical and cognitive disabilities in this care environment made obtaining feedback from residents on their experience of care challenging e.g. from a dependency study of 25 randomly selected residents undertaken in May 2000 by the Matron of Elderly Services, 68% of residents were found to have short and long term memory loss and only 8% of residents had no problems with communication. The observation tool Dementia Care Mapping (DCM), devised by the Bradford Dementia Group, is the most reliable and valid tool currently available attempting to measure the extent to which person-centred care is being delivered (Bradford Dementia Group, 1997). The tool is devised for usage in care homes for people living with dementia. The high prevalence of residents with memory problems (68%) at the nursing home indicated the tool may be relevant and useful in evaluating person-centred care in this generic long-term care environment.

In collaboration with the Home Manager, I secured funding from a local charity to pay for DCM activities and training. All staff were invited to attend a series of one day person-centred workshops provided by a psychologist with extensive experience in this field. These workshops were provided in May and June 2001. Staff were then invited to train as auditors (known as mappers) and to write a brief summary as to why they wished to attend the three day programme at Bradford University. Two care assistants (HCAs) and the manager were selected by myself to attend the course. We attended the DCM basic mapper training in July 2001. An examination at the close of the course authorises the use of the tool. Sadly all three participants failed the mapper examination at the end of the course and this was a serious blow in terms of self-esteem for my colleagues. I felt that I had somehow contributed to 'setting them up to fail'. This was made all the more painful because staff felt vulnerable and abused by the 'outside world'. The examination associated with DCM did go against the developmental spirit of action research, and whilst from a research perspective ensured reliability of the tool, it served to further undermine the confidence of project participants. It was an extremely stressful time for us all. However, two staff (the Home manager and HCA) with a lot of support re-sat the examination and were successful.

Two audits were undertaken using DCM and it did serve as a powerful tool for bringing about change. An outcome was the employment of a senior occupational therapist for two days per week. However, some staff felt angry about the findings of the audit as it was seen as critical of the care provided despite providing feedback in a sensitive and 'non-blaming' way. Perhaps in light of the emotional feelings generated staff struggled to make the link between individual resident DCM scores and translating this into care planning. In light of this situation and the distress caused by the examination, I wonder whether the simpler (although less rigorous) adapted DCM tool described by Bruce (2000) and Bruce and Wey (2001) measuring ill-being and well-being may have been a more useful tool in practice. These authors claim this tool can be more easily incorporated in care planning and this warrants further investigation.

4.1.7.6 Cycle 6: building networks

The transfer of the nursing home to a new acute Trust in 1999 meant new networks and links to the hospital had to be established. In addition, staff were concerned about being

'forgotten' and undervalued as a service. Staff reported the feeling that public and professional opinion of nurses in nursing homes was poor and felt denigrated by this. They felt that there was a lack of recognition of their skills, with little understanding of the difficulties and realities of their practice. Registered staff felt that they worked more autonomously than hospital colleagues due to the different provision of medical back-up within the nursing home. However, staff felt this level of responsibility was not valued or appreciated by other nursing colleagues. The closure of one NHS long term care facility in the previous five years and the local privatisation of NHS continuing care services served to remind staff that value was not accorded to the long term care of older people in the NHS. This climate of closure and privatisation within this part of the health economy appeared to contribute the low morale and isolation of this nursing service.

A variety of activities took place to try and address the isolation and marginalisation of the Home. In collaboration with senior managers, regular visits were made by the Chief Executive and her team. Other visits were made by the Nurse Advisor for Older People and the Chief Nurse for England and Wales. These visits were also arranged through my being involved with the larger CARP project. Staff described these visits by the 'top brass' as making them feel less forgotten. In addition, staff presented with myself at the bi-annual Royal College of Nursing elderly care conference in 2001 and a joint presentation was made to the Hospital Board in November 2002. Findings of the audits were presented as posters at the acute Trust's Quality Award Day in 2002 and 2003. All these activities were described by staff as putting the Home 'on the map' and bringing this service 'out of the shadows'.

This 21 month action phase produced six cycles of activity contributing to a less impoverished and more enriched environment. However, the major catalyst for change related to the surfacing of negative feelings (see page 117 for earlier discussion) that allowed the project to accelerate forward and positively impact on the quality of care provided. The improvements in care will be discussed below in the final evaluation phase.

4.1.8 Evaluation and project closure: January 2003-June 2003

This evaluation phase included a repeat of baseline audits (QUIS and Nursing Home Monitor II), repeat DCM and staff interviews (n = 22). All the information was fed back to participants and a final organisational report written. Agreement was given by staff, residents and family members (via the Friends of the Nursing Home group) to support the wider circulation of findings. A paper in a peer reviewed journal was published in collaboration with staff and the manager of the Home (Ashburner et al., 2004b).

Findings from the three audits showed improvements and all staff interviewed reported positive changes in the Home. Substantial improvements were found in the quality of interactions evaluated through QUIS and the quality of care as evaluated through Nursing Home Monitor II. There were reductions in the negative event recording and increases in resident well-being found in DCM. Staff interview data reported significant improvements in the cleanliness of the physical environment, reduction in nursing agency usage, improved staff morale and better relationships between staff and residents, amongst staff, and with the broader community. However, it was recognised that improvements still could be made in working more closely with family members and in some cases amongst staff teams. An unregistered staff member who had worked at the Home for 12 months provided this feedback:

> "The nurses no longer do the laundry and clothes are now properly marked, there are hot breakfasts, more fresh fruit and the food is edible, the hoists have got better, there are more hoists and these have been replaced by electrical ones. The general environment is good on this floor and this is because people work as a team. I have got to know a lot of residents but, some staff have not improved towards residents. I think this is because three years ago there was a very bad experience with a family and staff have not forgiven them and it is pretty frosty and the staff back off. However, it has got better and I would not have worked here three years ago. Staff tell me that it is 100% happier than three years ago, there are improvements in the activities and more resident outings." (Staff interview 3.7)

Arrangements were made for the continuation of clinical supervision provided by a newly appointed clinical psychologist and the development of the biographical booklet "Getting

to Know You" to support the ongoing collection of residents' life stories. The Manager of the Home joined a multi-professional one-year leadership development programme run by the Training and Development Department at the Hospital. The newly appointed occupational therapist took the lead on developing activities in light of the findings from the second DCM report undertaken in June 2003. The Friends of the Nursing Home established meeting dates for the up coming year and arrangements were made by the manager to support the administrator's presence at these evening meetings.

To conclude, this project took place in an impoverished and much maligned service in which staff felt misunderstood and abandoned. However, the three main interventions (biographies, clinical supervision and action learning) underpinned by psychodynamic and systemic approaches were powerful strategies in supporting the change process. The learning from this project comes from the systems of staff development (team supervision and action learning) necessary to support person-centred care. This approach of working with both staff and residents yielded positive results and can be recommended to other health and social care practitioners working towards more person-centred services. This model of working offers some interventions in 'how to' help care environments become more person-centred.

4.1.9 Postscript data: July 2003 – July 2004

At the close of the project, a management consultation exercise was underway to expand nursing services at the Home to include a community Continuing Care at Home Service. This community service had fallen under the management of the acute NHS Trust in 2000. These two services had been run separately due to being considered overly problematic by senior managers. However the positive changes at the Home now warranted the integration of these services. As I withdrew from the Home in July 2003, the manager of the Home was seeking promotion as the Matron of Continuing Care Services. She successfully applied for this new post. Within the nursing Home two new G grade posts were added to the management structure to lead the teams on each floor and an additional F grade post added to lead the Respite Service. All new posts successfully attracted applicants resulting in promotions for three staff. This investment

in the management and leadership of continuing care services is an important outcome of the project and has ensured the continued growth and development of the service. In addition, funding secured in 2003 saw the successful appointments early in 2004 of a part-time occupational therapist and psychologist to provide expertise and resources to help in delivering more person-centred services.

In January 2004, the acute NHS Trust advertised a post as Nurse Consultant: Care for Older People and I successfully applied. This felt an important organisational validation of the project and my work over the past four years. My new role will be focused upon acute care for older people but will allow for some ongoing work within the Continuing Care Service. I hope to support ongoing practice development in this care environment on taking up post in August 2004. I hope that by telling this story the reader has a clearer picture of the researcher journey and the main developments of this project.

I have written an account that can be easily understood and gives an overview of the research journey. However, for readers more interested in the detail of research activities, in the subsequent sections of the report I will give further in-depth information of locally agreed project aims, methodological approach, systems of data collection, findings and discussion of the findings.

4.2 Project Aims

4.2.1 Aims and objectives

The following project aims and objectives were derived through collaboration and consultation with research participants including staff, residents and family members. These were negotiated and agreed with staff at the close of the consultative phase in December 2000 (via circulation of the project proposal to all staff members and four staff meetings). Few amendments were made over time with the exception of the addition of the seventh project objective when the NSF for Older People was published in March 2001.

4.2.1.1 Project Aim

To explore the development of person-centred care for older people living in a NHS nursing home

4.2.1.2 Project Objectives

1. To promote dignity and respect for older people using Kitwood's (1997) concept of person-centred care

2. To address factors resulting in de-personalisation in the context of an NHS nursing home

3. To monitor the process and outcomes of multi-faceted approaches to practice based learning (clinical supervision, action learning, training programmes) in promoting person-centred care

4. To describe the issues of changing practice within a continuing care service

5. To raise the local profile of older people and to better meet the needs of vulnerable and frail older people within long term care

6. To develop gerontological care, striving to challenge negative stereotypes of older people and the staff that care for this client group

7. To locally implement and evaluate national policy standards on person-centred care (Department of Health, 2001a)

4.3 Methodology

4.3.1 Action research: definition, description and rationale

The spectrum of approaches to action research is diverse. Hart and Bond (1995) describe a continuum of approaches to action research from a consensus model of social change based upon rational social management, towards a more radical conflict model of change. Four typologies of action research are identified within this continuum: experimental, organisational, professionalising and empowering (Hart and Bond 1995). The approach adopted for this study is more orientated to the organisational and professionalising typologies, due to my previous experience, skills and training. It can be loosely described as the 'Tavistock approach' based upon a socio-technical perspective of action research and understanding organisations (Lewin, 1951; Miller & Rice, 1967; Trist, 1981). Pasmore (2001) describes the emergent synergies of Lewin's action research school and the Tavistock's socio-technical perspectives of the 1940s – 1960s.

> "Each came to believe that the predominant paradigm of the time, which was based on expert hierarchical control of social systems, would never prove adequate to face the challenges of a modern, post industrial society. Both felt that human dignity demanded that people have a role in setting the conditions that influenced the quality of their existence." (Pasmore, 2001: 44)

More recently Gould (2001) described this as 'systems psychodynamics' of organisations. This is a framework which attempts to integrate group relations theory, psychoanalysis and open systems theory to learning from experience and understanding organisational life and was also used to underpin methodological approaches described in the case study (see page 24 for earlier discussion and critique of this approach). To summarise there are two main tenets:

1. The structural systems in which people work impact on behaviour. This includes the division of labour, levels of authority, the nature of the work, the task of the organisation, and transactions across boundaries. These affect individuals in

significant psychological ways. Exploring and understanding these influences can positively support organisational understanding and learning (Gould, 2001).

2. Psychoanalytic theory provides a range of mental constructs (e.g. transference, resistance, projection and social defence systems) in which the emotional life of groups and individuals can be understood. The process of working through issues integral to a 'classic' therapeutic relationship is applied to the collective social defences (Menzies Lyth, 1988). This may create opportunities for learning and development. Awareness and insight through acknowledging and understanding difficult feelings is seen to be a hallmark of good professional practice from within this perspective (Hirschhorn, 1997).

This promoted active reflection on organisational and emotional constraints to changing practice. In line with a therapeutic model of working with clients, there was an open agenda for research participants to work through issues of their own choosing. The research process was led by the needs/issues identified by participants.

These main tenets of systems psychodynamics were integrated to the diagnosing, planning action, taking action, and evaluating spirals of action research described by Coghlan and Brannick (2001):

> "action research is about undertaking action and studying that action as it takes place. It is about improving practice through intervention, and demands rigorous preparation, planning, action, attention to process, reflection, replanning and validating claims to learning and theory generation." (Coghlan & Brannick, 2001: 84)

This particular approach was adopted because the authors describe a practical organisational approach underpinned by open systems theory, thereby linking theoretically with the 'Tavistock approach'. Coghlan and Brannick (2001) work from a model described as interlevel dynamics in which they identify levels of complexity: individual, group, inter-group, and organisational. They state:

> "The process of moving a change through an organisation requires a systemic view of complex interrelationship and interdependence of the individual, the face-to-face

team, the interdepartmental group and the organisation." (Coghlan and Brannick, 2001: 105).

From this systemic perspective of understanding organisations, these authors also identify three common attributes of action research. First, the approach is participatory, whereby research subjects are collaboratively involved in the research process and in a democratic partnership with the researcher. Second, the research process is itself is a force for change. Finally, the actions make a difference to those directly involved and the wider community (Coghlan & Brannick, 2001). The tenets of action research identified above in combination with a theoretical orientation of psychodynamics, open systems ideas and interlevel dynamics provided the framework behind the methodological approach adopted in this project.

4.3.2 The psychodynamic and systemic approaches adopted in this project

My understanding and work with these ideas in an organisational context were developed through undertaking a Masters in Consultation and the Organisation using psychoanalytic approaches at the Tavistock Clinic. The aims of the two year programme were to develop the student's capacity of self understanding in a working context and have a greater capacity to understand organisational, inter-group, interpersonal and intrapersonal issues that lead to functioning or dysfunctional teams. From a theoretical perspective I was introduced to papers on the individual unconscious, the group unconscious and the institutional unconscious and socio-technical open systems theory. These will be described in the sections below.

4.3.2.1 The individual unconscious

My perspective was largely influenced by the work of Melanie Klein. Her work examines how roles are generated in the mind and how the individual learns to relate to the external reality which enables a capacity for development (Klein, 1975). Based upon Melanie Klein's work with children in the 1920s, projective identification processes are seen as a part of healthy development, in which difficult and opposing emotions e.g. love and hate are projected outwards onto play characters. These characters take on the emotional

attributes of the projected feelings e.g. the wicked witch or the loving fairy godmother. This process can be viewed in two stages in which difficult emotions are kept split apart (all goodness residing in one character and all badness residing in another character) and at another stage in which there is a more integrated emotional picture (characters are seen as both having good and bad parts). However, if projections habitually remain split off and not integrated, Klein (1975) argues unhealthy psychological development will ensue. Klein (1975) describes a set of processes emotionally linking the individual with others and sets out a framework for seeing the interconnectedness of relationships through projective identification.

The important process within this action research project was the application of Kleinian theory to understanding my own experiences of projective identification as the lead researcher. Support to understand these processes were achieved through reflection, supervision and my own personal psychotherapy (see discussion of researcher reflections in section 4.6.1).

4.3.2.2 The group unconscious and institutional unconscious

The key elements of these unconscious processes are the understanding of group defenses against anxieties and in particular the seminal theoretical insights of Wilfred Bion. Bion (1961) studied groups and through his observations he came to view groups as being focused upon achieving the task of the group or anti-task tendencies. Bion (1961) argues that anti-task groups (or poorly functioning groups) demonstrated three important characteristics or *modus operandi*: flight or flight from reality, pairing up inappropriately, or overly dependent on a leader. Awareness of anti-task group behaviour was helpful to the researcher in trying to asses group functioning and the dynamics within teams and staff groups. The theoretical insights of group behaviour were particularly useful to the researcher in facilitating the staff supervision groups and action learning sets.

The theoretical ideas of the unconscious and the institution are best reflected in Menzies Lyth's (1988) work of the late 1950's. Menzies Lyth (1988) observed the social systems within a hospital nursing service which served to defend against the human anxieties involved in nursing work. Menzies Lyth (1988) argued that whilst the social systems helped in the defense against anxieties in the hospital setting, paradoxically were

unhealthy for the development of the nurses and contributed to the high drop out rate of student nurses in training. Whilst Menzies Lyth's work is nearly 50 years old, issues of poor retention still persist in student nurse training and I believe her work still has currency. Menzies Lyth's (1988) work helped inform me of the importance of social systems to ensure the healthy development of staff and in particular effective systems of staff support.

4.3.2.3 Socio-technical open systems theory

Open systems theory is drawn largely from an ecological model of the interconnectedness of systems and homeostasis (Bertalanffy, 1950). Systems approaches have more recent links with the trans-disciplinary field of cybernetics which can be described as the science of effective organisation (Beer, 1977). A systems approach is the study of physical and social systems which enables complex and dynamic situations to be understood in broad outline. The approach is particularly useful in alerting researchers to interactions or sub-systems previously unrecognised in the system. The conceptual model involves inputs and outputs across boundaries in order to maintain survival and growth (Zagier Roberts, 1994). This has received criticism from Marxist theories who argue that open systems theory maintains the *status quo* (Brown, 1992). However, despite the biological orientation of this theory there are useful concepts such as boundaries, task and authority and organisational structures which have helped shape my understanding of organisational life. In line with open systems theoretical perspectives I paid particular attention to the organisational boundaries around the Home as an indicator of how the organisation functioned e.g. how the door entry systems was managed. The work of Coghlan and Brannick (2001) on interlevel dynamics was also drawn from this theoretical perspective and supported the practical application of this perspective to the research process (see later discuss in section 4.3.5).

4.3.3 Role of the lead researcher in this action research project

My role in this project was different from more traditional research approaches. There was active engagement and involvement with research participants underpinned by egalitarian and democratic principles engaging in inquiry *with* and *for* people as opposed to

on subjects (Reason & Bradbury, 2001). This stood alongside a commitment to evaluate the change process.

4.3.3.1 Attributes of the role

My role is perhaps best seen as that of internal consultant as described by the Tavistock Clinic organisational consultants Huffington & Brunning (1994). This type of consultancy is a process involving a consultant who is invited to help a client on a work related issue and is based upon the model of process consultancy (facilitative and empowering) as opposed to an expert consultancy approach (solution based and prescriptive). The client in this project was a group of staff and residents working/living in the Home. Huffington and Brunning (1994) state:

> "The responsibility for *fulfilling the task* of the organisation lies with the client in the consultancy process, whereas the responsibility for the consultancy *process* lies with the consultant." (Huffington and Brunning, 1994: 13)

Internal consultancy involves consultancy to individuals, groups, or the whole organisation of which the consultant is also a member. In this project, the researcher/internal consultant had worked in the organisation for four years prior to starting the project, which supports Huffington and Brunning's claim that the internal consultant can offer local knowledge and signify the ownership of change in an organisation. I had previously established good networks in the hospital and this familiarity with the larger system was useful during the project, particularly the case as the nursing home was off site to the main hospital. An example of 'insider' knowledge was the support of a successful application made by the Manager of the Home for £5,000 to a hospital charity to fund opportunities in person-centred workshops for staff and DCM training at Bradford University. The Manager of the Home did not know about the existence of this opportunity for nurses to access charitable funds. However, throughout this project the researcher was salaried by the University but held an honorary contract with the NHS Trust. At the beginning of the project, a choice was offered to all the CARP researchers as to where each of postholder wished to locate their employment contracts (either NHS Trust or University). My decision was to hold a University contract but this decision was fairly arbitrary and did not directly impinge on the 'insider'

or 'outsider' status. Of the seven CARP researchers, three postholders held contracts with the University. During this project my main organisational 'home' was the NHS Trust (four days per week with one day per week at the University) and I was salaried to work to this NHS Trust's agenda.

Paradoxically whilst being an 'insider' to the acute NHS Trust, I had little or no previous contact with participants at the Home prior to the commencement of the project. This meant I was an 'outsider' to the Home at the project's inception. This was supported by the fact that the Home had transferred to the acute hospital only three months before the project began. This combination of being both insider (through previous employment in the organisation) and outsider (negligible contact with the study site prior to the commencement of research activities) gave the researcher both an extensive system of networks and contacts yet a freshness of perspective coming to work with a new service in the organisation.

The arrival of an internal consultant/action researcher simultaneously creates a new context of an observed system – observed by a person *outside* the immediate system. Both the observer and the observed have their own set of expectations which is part of the observing system (Huffington and Brunning, 1994). This is illustrated in Appendix One on page 273. The key issues influencing the observer position was the transition of the researcher from the previous managerial role held in the organisation to internal consultant/researcher. This was supported through supervision activities with the academic lead, individual supervision with an external consultant and joint supervision with the Matron of Elderly Services to explore the interface between management and research agendas. In addition, research participants had beliefs about being observed. Over the project, I worked to allow the surfacing of many negative beliefs about the researcher's role. There was a substantial mismatch between senior managers' view of the researcher as an added bonus and 'luxury item' as opposed to the Manager of the Home and many of the staff who saw the researcher as a threat who would 'stir up trouble'.

4.3.4 The facilitative approach adopted during the project

The following description describes the facilitative stance I adopted in supporting change through action research. It is based upon the Coghlan & Brannick's (2001) approach to action research melding with the 'Tavistock model' of organisational change.

4.3.4.1 The inward focus

This inevitably involves the background and experience of the researcher. It is about who she or he is as person. Perhaps most significantly for this project I had completed a postgraduate programme in applying psychoanalytic theory to organisational consultancy. This influenced the stance and style of the researcher. I was attentive to my own feelings about the project in order to appreciate and better understand the dynamics of the organisation e.g. if the researcher feels angry and distressed, consideration is given to the ways this emotional response connects to the experiences of those in the organisation. Psychoanalytic theory offers a framework for understanding emotional experience. Support for the researcher in this field was sought through supervision with a psychotherapist and organisational consultant. In addition, membership of an action learning set, served to promote reflection and self awareness through feedback from set members.

4.3.4.2 The outward focus

Learning about what was happening for the team and organisation was through participant observation e.g. interviews, team supervision, attendance at meetings, and teaching activities. I wrote up notes and reflections on these experiences. This outward focus involves looking at the system as a whole and noting the task and function of the organisation, authority and leadership, boundaries in the system, methods of decision-making, organisational roles and policies.

4.3.4.3 Engaging others in the inquiry process

The engagement of others in the inquiry process is the major distinction between action research and more traditional approaches to research. The engagement of participants was a crucial ingredient in the process of change. Coghlan and Brannick (1994) cite Schein (1999) who describes three levels of inquiry in engaging others. The first phase is called *pure inquiry* and prompts the telling of a story; "What is going on and tell me what

happened?" The next line of inquiry is the *exploratory diagnostic inquiry* in which the content is analysed; "How do you feel about this? Why do you think this has happened? And what did you do?" The third type of inquiry is the *confrontive inquiry* and challenges the other to think from a new perspective; "Can you think of an alternative way of approaching this? And what else might you have done? These levels of inquiry offer a simple framework for the engagement of others in the action research process.

The boundaries of the researcher role were primarily negotiated with the Matron of Elderly Services. The only managerial constraint was that the research project would take place within the Home. However, there was no pressure to work to managerial agendas and I was given freedom to work with the needs of the staff and residents of the nursing home.

The management of the research project involved attention to all relationships and building support for the project. Coghlan and Brannick (2001) argue that at all levels in the organisation people will ask; "What is she observing? And am I being criticised?" The internal consultant/researcher has to tread a fine line. This is between being perceived as too cautious, and thereby seen as 'an extra pair of hands', or being perceived as too challenging and disloyal and running the risk of being a scapegoat (Huffington & Brunning, 1994). Joint supervision with the senior manager to explore the interface between research and managerial developments helped to maintain a healthy balance between being too cautious or too challenging.

These key attributes of the internal consultancy/researcher role described above, in essence provide an overview of the role of the main investigator in a project of this nature.

4.3.4.3 Project steerage

A steering group was established to monitor study progress. It was used to discuss emerging issues arising from the project's development. It also served as a forum to share the developments within the nursing home with senior staff in Older People's Services and the Medical Directorate within the hospital. The group met on eight occasions (1.5 hours on each occasion) during the study period. The steering group

consisted of: Senior Nurse for Medicine (chair), Matron for Elderly Services, the Manager of the Nursing Home, Team Leader of the Home, Manager of the Older People's Assessment Unit, Manager of the Community Continuing Care Service, the Project Director for CARP, the Carers' Liaison Specialist, Consultant Geriatrician, and Practice Development Nurse (medical directorate).

4.3.5 The action researcher as an instrument of the research process

In qualitative methods of inquiry (inclusive of action research) the researcher not only collects data but serves as 'the instrument' through which the data are collected (Rew, Bechtel and Sapp, 1993). These authors describe the 'self as instrument' advocating the researcher needs to include details about the self in order to ensure a rigorous research process. A description of myself in this research process is evident in section 4.1 via the story of the research process and in particular professional and personal details on p.107. The attributes of the researcher as instrument are described by Rew, Bechtel and Sapp (1993) as authenticity, credibility, intuitiveness, receptivity, reciprocity and sensitivity. I recognised that keeping true to these attributes was challenging and sought out a number of support systems to help me be 'good enough' through the research process. These systems included not only regular academic supervision, but also active membership in a monthly action learning set, bi-monthly supervision with a psychotherapist working on my group facilitation skills and my personal bi-weekly psychotherapy. I also had peer support from the team of action researchers and the support provided by the project co-ordinator. All these systems of support helped my personal growth, self reflection and development through out the research journey.

Interestingly Rager (2005) comments upon compassion stress as the emotional work for the qualitative researcher and states

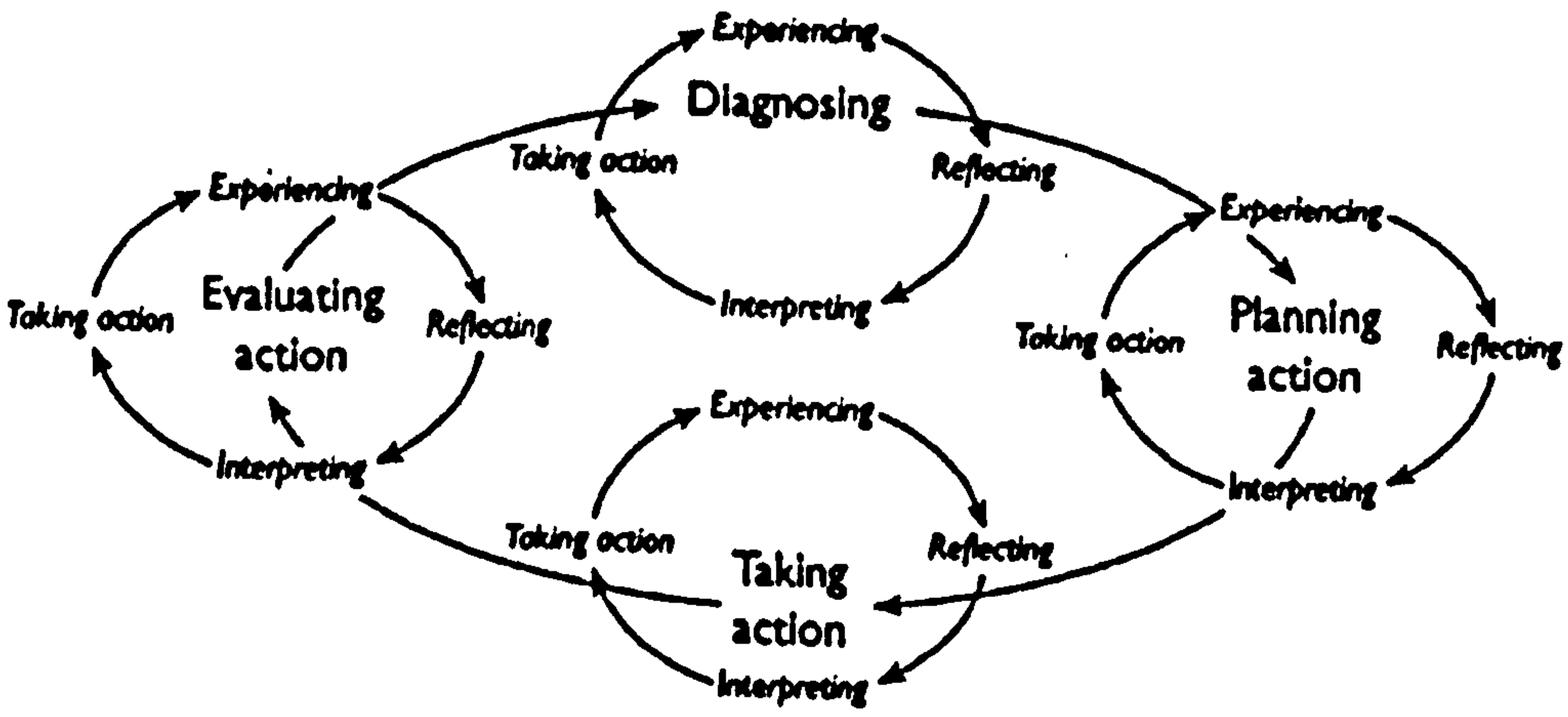
> "Human subjects are carefully protected in the research process. However, the same consideration is not given to the qualitative researcher, even those investigating topics that are likely to elicit powerful emotions. The role of the

> researcher's emotional responses and self–care strategies....have not received the attention they deserve in the qualitative research literature." (Rager, 2005: 423)

The systems of support established through the CELEC Action Research Project (CARP) (peer support, action learning, regular academic and clinical supervision) were extremely helpful in safeguarding against 'compassion stress' and supporting the researcher as instrument in the action research project. However, I also took on additional 'self-care' activities beyond the formal systems of support provided in the project through personal psychotherapy. I believe this level of support and development was intensive but contributed to the 'success' of this project and my role as researcher as instrument. However, I would endorse Rager's (2005) statement that this area of emotional work does deserve further examination within the field of qualitative research.

The core of the action research process lay with diagnosing, planning action, taking action and evaluating action (Coghlan & Brannick, 2001). A critical feature of action research and my role of action researcher was how I learned about myself in action, helped others to learn in the immediate system and how the wider community was influenced. These levels of learning were integrated to organisational experiential learning process (see diagram 2 below).

Diagram 2: The experiential learning cycles in action research projects (Coghlan & Brannick, 2001: 30)



These learning cycles were part of the data collection, analysis and evaluation process of the research. These took place in the following way and represent the key elements of the of this research process:

1. Systematically collecting research data about the Home in relation to an objective or need

2. Feeding back the data to relevant others

3. Conducting a collaborative analysis of the data

4. Planning and taking collaborative action

5. Jointly evaluating the results of that action

These cycles of action research facilitated by the researcher were implemented into the research process at three levels. These levels are informed by systemic and psychodynamic thinking described by Coghlan and Brannick (2001) as interlevel dynamics. In addition, the researcher also drew upon the dimensions of psychosocial practice described by the Tresolini Pew-Fetzer (1994) as part of relationship-centred care. These levels were:

- the researcher's development,

- the development of research participants in the Home,

- the broader organisation development and in particular managerial learning.

For the purposes of this study the conceptual framework of interval dynamics and the psychosocial dimension of care have been utilised to help in the data analysis process and the reporting of the findings in this project. Further detail on the application of these levels is described below.

4.3.5.1 Level One: The researcher's development

This was ensured through the systems of supervision available to the researcher during this project (see earlier discussion on p.142). This involved attendance at regular supervision sessions with a psychotherapist and organisational consultant, academic supervision with the Project Director, and monthly action learning with researcher peers

and facilitated by the project co-ordinator. The data collection of the researcher's reflections on these meetings was through field notes made after the meetings. An audit trail of data analysis included recording of notes, re-reading notes, sharing ideas in supervision sessions, seeking feedback with supervisors, peers and participants then re-evaluating my perspectives. In addition the personal development of the researcher was supported through regular psychotherapy during the study period.

4.3.5.2 Level Two: The development of research participants in the Home

This second level involves the research participants directly involved in the research and constituted the researcher, the residents, family members and staff in the Home. They represent participants who were the 'grassroots' of the project. Data collection within this level included field notes of all meetings, audit findings and transcripts of interviews. Within this level, the Tresolini Pew-Fetzer Taskforce (1994) made the helpful distinction between practitioner-client relationships and practitioner-practitioner relationships and these dimensions were used to assist data analysis and the presentation of findings (see section 4.5.7.1 for detailed findings). An audit trail of data analysis involved reading and reflecting on field notes/interview data/audit findings, presenting ideas and feedback to participants, agreeing actions and then putting these actions into practice and then subsequently re-evaluating. These processes of analysis are most evident in the reporting of findings during the intervention/action phase (see section 4.5.6) over two years in January 2001 and December 2003.

4.3.5.3 Level Three: Organisational development and managerial learning

This broader level of influence draws upon the wider community outside the Home. The particular focus the researcher adopted was upon the active engagement of managerial systems supporting the Home. This took place through monthly joint supervision sessions with the Matron of Elderly Care Services, action learning for nurse managers in Elderly Care Services (both in general hospital and mental health services) and meetings/presentations with the senior executive team in the hospital. Data collection took place through recording field notes and interview transcripts obtained through discussions with senior managers. An audit trail of data analysis involved the researcher reflecting on project's influence at managerial levels in the organisation, evaluating actions and analysing feedback with senior colleagues.

To summarise, the cycles of action research including diagnosing, planning action, taking action and evaluating action were amalgamated with three operational levels of practice drawn upon the systemic approaches described Coghlan and Brannick (2001), the psychodynamic approaches from personal experience in therapy and more formal training through the Tavistock Clinic and conceptual model advocated in the relationship-centred care described by the Tresolini Pew-Fetzer Task Force (1994). This describes my role as a research instrument and its influence upon the research process.

4.4 The three phases of data collection

Data collection during this three-year project was a dynamic process, but for ease of understanding it can best be described in three phases:

- The consultation phase (January 2000-March 2001)
- The action phase (April 2001-December 2002)
- The evaluation phase (January 2003-June 2003).

Throughout the three phases a variety of qualitative and quantitative methods were used. Each phase included the dynamic activities of experiencing, reflecting, interpreting and taking action (see earlier diagram on page 143). It is important to note that the focus of this section is to give the reader an understanding of the methods of data collection, with minimal contextual information, to explain adequately how data collection occurred within each phase of the project and as part of each action cycle. The detailed findings from each phase of the project and the action cycles are presented from page 173.

4.4.1 Consultation phase (January 2000-March 2001)

The purpose of the phase was to identify the context of nursing care provided in the home. It provided a baseline from which to measure change over time and informed the second action phase of the study. A multi-method approach to data collection was used. An important part of this phase was building relationships, starting to understand the context of care, identifying quality of care issues and working with participants to clarify their issues within the service. During this period I worked part-time (1.5 days per week at the Home with the 1 day at the University). The remainder of the week was spent facilitating the RCN Clinical Leadership Programme within the acute NHS Trust. This phase was characterised by problematic and difficult staff relationships due to mistrust and concern about the role of the researcher as discussed in the research story on page 115.

Appreciating the context of care through consultation and starting the process of building relationships with staff, residents and family members occurred through the following activities:

1. Formal staff meetings called around the project's development (n= 2)

2. In-depth interviews with family members (n=2) and residents (n=2)

3. Seven supervision meetings with the Manger of the Home in which the researcher acted as clinical supervisor

4. Joint supervision meetings with the Matron of Elderly Services facilitated by an external consultant (n=5)

5. Observation through participant and non participant activities (n = 4 nursing shifts for participant observation)

6. Exploratory two hour workshops on the management of abuse situations in care for staff (n = 12 workshops)

7. Field notes

8. A mapping exercise of services available for older people across the borough carried out as part of the induction activities in taking on the CARP researcher role.

The quality of care was explored through:

1. A shortened version of a quality interaction tool (QUIS) (Dean, Proudfoot, & Lindesay, 1993)

2. Nursing Home Monitor II – quality of care audit tool designed for usage in nursing homes (Morton et al., 1991)

3. Eight staff meetings took place to feedback the results of the audits. Two meetings took place to discuss Nursing Home Monitor II findings and six meetings took place to present QUIS findings.

4.4.1.2 Data collection concerning the context of care in phase one

This included a range of data generating activities including both observation and informal interviews and formal meetings.

4.4.1.2.1 Formal staff meetings around the project:

Unfortunately due to the staff difficulties associated with the presence of the researcher in the Home during this phase, no invitation was forthcoming from the Manager of the Home for me to attend staff meetings. I respected this decision. Only two formal meetings occurred in February and June 2000 concerning the project. Twelve staff members attended in February and ten staff members attended in June. At the first consultation meeting staff were asked what they would wish to see changed and improved upon in the nursing home. At the second meeting staff were asked to consider the strengths, weaknesses, opportunities and threats facing the nursing home in the light of the project. Notes were taken at each meeting on flip charts and the summary findings circulated to all staff after each meeting.

4.4.1.2.2 In-depth interviews with family members and residents:

Two in-depth interviews with two family members took place, with each interview taking 1.5 hours. Tape recording was refused in both cases and notes were taken. In addition, two interviews took place with residents. These interviews were unstructured and focused on the experience of the resident in the Home. Additional notes were made after each meeting.

4.4.1.2.3 Clinical supervision meetings with the Manager of the Home:

Sixteen meetings were scheduled and seven meetings took place. A contract was established between the researcher and manager concerning confidentiality and establishing an open agenda for the manager to raise work issues. In the light of this process, a decision was reached by the Manager to join a group of peers for clinical supervision on the main hospital site facilitated by an external supervisor (see page 10 for details on clinical supervision developments). This was an important step in ensuring the

Manager received support outside of the project from a group of peers and an experienced clinical supervisor. However, the termination of the clinical supervisory relationship with the researcher was indicative of the lack of trust and difficulties experienced by the Manager of the Home.

4.4.1.2.4 Joint supervision with the Matron of Elderly Services:

Monthly meetings between the Matron for Elderly Services and myself were established in June 2000 (which subsequently ran throughout the project) and five meetings took place within this phase. The purpose of these meetings was to explore the interface between research and managerial agendas. They were set up because of the complexities and difficulties around the start of this project. An organisational consultant with knowledge and skills in systemic and psychoanalytic perspectives facilitated the meetings.

4.4.1.2.4 Participant observation:

I worked 4 nursing shifts between July-August 2000 as a nurse (two shifts starting at 7.30 a.m. and two shifts starting at 13.30). On all occasions I was allocated to work with health care assistants. Field notes were taken after each shift. The field notes did not follow any particular structure but commented on activities undertaken and any associated emotional experiences I had.

4.4.1.2.5 Non-participant observation:

Formal non-participant observation occurred during audit activities undertaken, including QUIS and Nursing Home Monitor II (see page 151 for further details). Informal activities included time spent over the year with staff and residents 'getting to know' people and involved discussions in the coffee room, in the nursing offices and corridors of the nursing home. These informal contacts were incorporated into field notes.

4.4.1.2.6 Workshops on abusive situations in the workplace

From September 2000 onwards 12 workshops were run to provide an opportunity for all nursing and domestic staff to respond to video material provided by the charity Action on Elder Abuse about the dilemmas care staff face in Care Homes concerning abusive situations (Action on Elder Abuse & Department of Health, 1999). Field notes were taken on the staff's experience of abusive situations presented in the video and the issues emergent in the debates.

4.4.1.2.7 Field Notes

I kept a daily record of events kept in the form of unstructured field notes. Entries were made regarding both formal and informal meetings, discussions with participants, observations made, reflections on formal data collection activities and my impression of care. Attention was always paid to the researcher's emotional response to experiences in the Home and these feelings were recorded in the notes.

4.4.1.2.8 Mapping exercise

During this period a mapping exercise was undertaken to identify the local resources for older people. A variety of organisations providing care for older people were visited or contacted including community health schemes, local charities and social services. Three visits were made to two local private nursing homes in the borough.

4.4.1.3. Data collection regarding the quality of care

All of the data collection activities above contributed to appreciating the quality of care provided. However, two audits (QUIS and Nursing Home Monitor II) were completed to measure the quality interactions of nursing care within the Home. These audits were utilised as baseline measures and were repeated at the close of the project. Positive steps were taken to involve staff in audit activities and three staff trained as auditors to support data collection. In the light of the difficulties within the Home concerning the presence of the researcher, the involvement of staff in this process was considered to be vitally important. Training time with staff was a useful way in building relationships and helping reduce suspicion.

4.4.1.3.1 Shortened quality interaction schedule (QUIS)

The quality of social interactions between nursing staff and residents was measured using a shortened version of the QUIS tool (Dean, Proudfoot, & Lindesay, 1993) as recommended by the Health Advisory Service 2000 who have an excellent track record of elderly care service evaluation (HAS 2000, 1998). Data collection occurred through non-participant observation of 15 minutes duration on eight occasions (4 observations on each floor of the Home) over 48 hour periods. Four categories were used against which interactions were coded:

Positive social interactions – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.

Basic care interactions – basic physical care with task carried out adequately but without the elements of social or psychological support as above

Neutral interactions – brief indifferent interactions not meeting the definitions of other categories

Negative interactions – care provided which is disregarding of the residents' dignity and respect

This tool measured psychological, emotional and attitudinal aspects of care. The findings were written up as a report and circulated to staff. In addition, six meetings with staff took place to feedback the findings verbally.

4.4.1.3.2 Nursing Home Monitor II

The quality of nursing care on the two floors within the nursing home was measured using the validated Nursing Home Monitor II audit tool (Morton et al 1991). Data were collected through documentary analysis, non-participant observation, and structured patient and nursing staff interviews in the following areas:

- Home management
- Patient welfare
- Nursing care: admission information and collection, care delivered, medication, practical nursing, nutrition and social care.

The care provided for 20 residents was audited over a five day period by three auditors. All residents were randomly selected to avoid any bias. A meeting with four senior staff took place to review findings along with the presentation of key findings at a team away day (14 staff members) and finally a written report was circulated to all staff.

The two tools provided complementary but differing information. The former tool (QUIS) gave a quantitative indication of the milieu of care, whilst Nursing Home Monitor II rated the practicalities of care e.g. record of admission information.

4.4.2 Action phase (March 2001-December 2002)

In the light of the feedback of findings to participants from the data collected in phase one and consultation over future research activities, six cycles of action subsequently took place during this second phase. Participation in action cycles was a collaborative and voluntary process. All action cycles were working towards the development of person-centred care and set out to achieve the following:

1. To develop understanding of the lives of residents through collecting biographical information
2. To build staff development and promote learning through clinical supervision
3. To promote leadership and management development through action learning
4. To foster user and carer involvement
5. To evaluate person-centred care through audit
6. To improve networks and links with other organisations/services to share and support good practice.

A variety of qualitative and quantitative methods were used to measure the process and outcomes of these action cycles. For each action cycle, a brief summary of presenting issue informing the cycle is given to help the reader relate the cycles to the issues emergent from phase one, followed by a summary of the activities and initiatives undertaken in each cycle and the data collection methods used.

4.4.2.1 Cycle One: To develop understanding of the lives of residents through collecting biographical information.

4.4.2.1.1 Summary of issues informing the cycle – depersonalisation of care

Documentary records within the nursing care plan always reported the medical diagnosis of residents, alongside the physical and psychological deficits but invariably contained little or no biographical information. Staff identified that due to the cognitive impairment of residents, collecting biographical information presented a difficulty. They reported that even if a resident had lived in the home over a long period they often knew very little about the resident's previous life. Residents and family members reported feeling positive about telling life stories but believed staff may be too busy or not interested. Kitwood (1997) argued that knowing the person and not just the disease is a vital ingredient in providing person-centred care. Collecting biographical information is integral to person-centred care and staff felt this could be a helpful strategy to bring about change.

4.4.2.1.2 Taking action: biographical activities undertaken during phase two of the project

Twenty-one biographical interviews were undertaken in which I facilitated staff through the process. The process involved ten key steps which were as follows:

1. A nurse would voluntarily identify a resident with whom she/he wished to undertake a biographical interview.

2. A preparatory meeting between the staff member and myself would take place prior to each interview to discuss the process, develop an interview schedule and consider the ethical issues. Staff were provided with a biographical tool called Memoraid (Glover, 1994) to help them prepare for the biographical interview. The decision to utilise this tool was at the discretion of the staff member.

3. Negotiation with resident and family member concerning the process.

4. Consent for the interview was obtained.

5. Nineteen biographical interviews were undertaken with a resident/family member, staff member and researcher present (two interviews completed by registered staff independently).

6. A debriefing meeting was held with staff after the interview.

7. Feedback to and negotiation with the resident/family member took place concerning written biographical details and the sharing of collected information.

8. The staff member was supported in sharing the experience of undertaking biographical interview in a subsequent clinical supervision session.

9. Facilitated reflection with colleagues on the process of the biographical interview through clinical supervision.

10. At the close of the project I worked collaboratively with staff, residents and family members to develop a biographical booklet called 'Getting to Know You'.

4.4.2.1.3 Data collection

Written summaries of biographical details were collected during the interviews (n = 21). I recorded biographical information during the interviews (as well as notes provided by nurses who independently undertook interviews). In addition, I made field notes on the process of undertaking a biographical interview with each resident/family member. I took notes after every clinical supervision session.

The data collected were extensive, containing detailed biographical material provided by residents and family members, notes on the researcher's experience and reflections by staff on the biographical material presented in clinical supervision sessions. This action cycle was emotionally demanding but was frequently viewed by the researcher and participants as an enriching and positive experience. Findings from this cycle are discussed on page 194.

4.4.2.2 Cycle 2: To build staff development and promote learning through clinical supervision

4.4.2.2.1Brief summary of issues informing the cycle - problematic team working

From data collected in phase one, the staff reported difficulties with team working and tensions between registered and non registered nurses. Group supervision for each nursing team was offered to staff to provide an arena in which team-working issues could be explored. In addition, giving staff the opportunity to set the agenda and focus of discussions in clinical supervision modelled a person-centred approach to interactions and relationships. In addition a substantial proportion of staff (45%) had over 20 years experience in the NHS and were experienced practitioners. The experiential approach to learning offered through clinical supervision provided a mechanism for exploring and sharing the learning gained through the many years of NHS service.

4.4.2.2.2 Taking action: regular team supervision meetings

1. Regular sessions for each nursing team took place for one hour on a weekly basis over 21 months (scheduled breaks over holiday periods) with attendance of between 4-12 nurses at each session

2. All sessions were facilitated by the researcher

3. Recorded ground rules were agreed by each nursing team and given to any new team members wishing to undertake supervision

4. Three evaluation sessions took place over the 21 month period

5. Regular (approximately every 2 weeks) supervision of my facilitation of the groups took place with an organisational consultant/psychotherapist.

4.4.2.2.3 Data collection methods used

Notes were written up by me (whenever possible) immediately after each session (n = 104 sessions recorded).

Notes of the researcher's own supervision recorded (whenever possible) immediately after each session (n = 30 sessions recorded).

Records of staff attendance at sessions were kept.

Extensive data collection about action, reflection and learning through clinical supervision for both staff and researcher occurred during this phase. The writing up of notes on each clinical supervision session with staff generally took me between 1-3 hours. Written records of the researcher's supervision sessions generally took between 30 minutes to one hour after each session. These notes provided a rich data source of the development of the project over time.

4.4.2.3 Cycle three: To promote leadership and management development through action learning

4.4.2.3.1 Summary of issues informing the cycle- no previous leadership development opportunities available to the Manager of the Home

The pivotal role of effective management and leadership was considered by both the senior managers and myself to be a vital ingredient for the likely success of this developmental project. In addition, policy recommendations advocate the strengthening of nursing leadership (Department of Health, 1999a) and clinical leadership development has been recognised as a key factor in supporting the implementation of the NSF for Older People (Department of Health, 2003). Leadership development opportunities had not been available to the Manager of the Home prior to the commencement of the project and action learning was adopted as a mechanism to support learning. The Home was off site to the main hospital and at risk of being isolated. Networks, systems and relationships to the hospital were new.

4.4.2.3.2 Taking action: action learning set for nurse managers of elderly care services

Key steps involved in this action cycle are identified below:

1. Information and presentation about action learning to interested managers (two workshops).

2. Invitation to managers to voluntarily join the set.

3. Eight nurse managers of elderly care services agreed to participate in action learning (three managers from the acute Trust and five managers from the mental health Trust).

4. Agreement of ground rules in both 2001 and 2002.

5. Twenty-seven monthly ALS meetings took place from January 2001-March 2004.

6. Three evaluation reports of ALS meetings were written by the researchers in collaboration with set members and submitted to senior managers in order to secure ongoing managerial support and to provide a progress report of outcomes associated with the action leaning.

The process of action learning involved alternating the facilitation with my colleague every month. When not facilitating, I would take an observer role, taking notes to record each set meeting and give feedback and support to my researcher colleague. My colleague reciprocated this role when I was facilitating the learning set. In collaboration with participants action points were agreed each month by each presenter in the set, and followed up and reviewed at the next meeting.

4.4.2.3.3 Data collection methods used

Detailed notes were taken by observer on set meetings (16 set meetings recorded).

The agreed action points were formally circulated after each meeting (15 set meetings).

Three action learning evaluation reports were completed and undertaken after 6 months, 12 months and 27 months of action learning.

Records of all agreed ground rules were made.

Extensive notes were written up after each ALS meeting by whichever researcher was in the role as observer. This process of recording generally took between 4-6 hours per meeting. The support of the CARP research colleague in action learning certainly added rigour to the data collection concerning this cycle.

4.4.2.4 Action cycle 4: To foster user and carer involvement

4.4.2.4.1 Summary of issues informing this cycle – no Carers' Group

A previous carers' group in the Home had disbanded in 1997 due to a particularly motivated family member becoming unwell. The group had subsequently declined and then stopped meeting. There was general consensus from staff and managers that another group should be re-convened if there was adequate interest from residents and family members.

4.4.2.4.2 Taking action: Re-launching the Carers' group

Key sets in this action cycle were as follows:

1. Discussions through steering group meetings in 2001 concerning issues related to user and care involvement led to interest in establishing a group known as 'the Friends' of the nursing home.

2. A social event (live singer and bar) took place in October 2001 organised with residents, family members and staff to sound out interest in establishing 'a Friends' group.

3. Invitations were sent to all family members and residents concerning the establishment of 'the Friends' in November 2001 with the first meeting taking place on 21st November 2001.

4. Four 'Friends' meetings occurred in 2002.

5. Minutes of each meeting were circulated to the next of kin of all residents.

6. Drinks and snacks were provided after each meeting to encourage socialising between family members and staff.

7. Feedback of research findings and circulation of an interim research report to this group (August and October meetings in 2002) established a sounding board for the views of residents and family members.

8. Surgeries with the Manager of the Home were offered to family members (commenced in October 2002).

4.4.2.4.3 Data collection methods used

The agenda and minutes of the five 'Friends' meetings were recorded by me and circulated to family members, residents and staff.

Written notes were made of semi-structured interviews (for interview schedule see appendix on page 274) with 12 residents and family members and 12 staff members with regard to evaluating care and identifying future changes.

I recorded feedback from staff raised through supervision meetings.

I kept field notes on my experiences at the Friends meetings.

4.4.2.5 Cycle 5: To evaluate person-centred care through audit

4.4.2.5.1 Summary of issues informing the action cycle – using a widely recognised tool

At the close of the consultation period the agreed aim of the project was the development of person-centred care. The most reliable and valid tool for the measurement of person-centred care is DCM (Brooker, Foster, Banner, & Payne 1998).

4.4.2.5.2 Taking action: using DCM:

1. Application for funding for training made to local charity.

2. Successfully obtained £5,000 towards staff training in person-centred care and Dementia Care Mapping (DCM) at Bradford University.

3. Invitations sent to staff asking if they wished to undertake a training programme in DCM at Bradford University.

4. From the 16 positive responses, two care assistants were selected from each floor, the researcher and the Manager of the Home undertook the training programme at the University of Bradford.

5. All staff were offered the opportunity to attend a one day training programme on person-centred care provided by a recognised expert in the field.

6. Two training days on person-centred care took place in July 2001 and 32 staff members attended.

7. Training on DCM at Bradford University completed by three staff members and the researcher on June 25-27th 2001.

8. DCM took place on the ground floor and top floor in October and November 2001.

9. Reports on the findings of DCM circulated to staff in October and November 2001.

10. A report was also circulated to the Head of Therapies and consultation took place with regard to funding for a registered occupational therapist to support the part-time occupational therapy assistant at the nursing home.

11. In light of DCM findings an Activities and Social Care Group was established in November 2001.

12. Three further meetings of the activities and social care group took place in 2002.

13. Visit arranged to local dementia unit (recognised as a centre for good practice) for a one day course on person-centred care in April 2002.

14. Range of social activities including Jubilee party, BBQ, regular live entertainment, 'sweet memories' afternoon.

15. Art therapist input for residents (one day per week) commenced in April 2002.

16. Pet therapy commenced in November 2002.

17. Formal links established with befriending/volunteer group through local charity.

18. January 2003 commencement of a part-time occupational therapist (one day per week) at the nursing home. This was a collaborative development with the mental health services and is a joint appointment with a local dementia care unit.

19. Repeat DCM in late June 2003.

4.4.2.5.3 Data collection methods used

Each DCM recorded observational data over a 6 hour period on the well-being and ill-being for 16 residents in November 2001 (and 13 residents in June 2003). Observations were recorded every five minutes. All observations occurred in communal areas. The well-being and ill-being categories were as follows:

Table 2: Wellness and ill-being data (know as WIB scores) in DCM

+5	Exceptional well-being – it is hard to envisage anything better, very high levels of engagement, self expression and social interaction
+3	Considerable signs of well-being; for example in engagement, interaction or initiation of social contact
+1	Coping adequately with the present situation; some contact with others; no signs of ill-being observable
-1	Slight sign of ill-being visible; for example boredom, restlessness or frustration
-3	Considerable ill-being; for example sadness, fear or sustained anger; moving deeper into apathy and withdrawal; continued neglect for over half an hour
-5	Extremes of apathy and withdrawal, rage, grief and despair; continued neglect for over one hour

During each five minute interval over the continuous six hour DCM observation period, a behaviour category was also recorded for each resident. The behaviour categories were as follows:

Table 3: DCM behaviour category codes

Code	Memory Cue	General description
A	Articulation	Interacting verbally or otherwise (with no other obvious activity)

B	Borderline	Being socially involved but passively
C	Cool	Being socially uninvolved, withdrawn
D	Distress	Unattended distress
E	Expression	Engaging in an expressive or creative activity
F	Food	Eating and drinking
G	Games	Participating in a game
H	Handicraft	Participating in a craft activity
I	Intellectual	Activity prioritising the use of intellectual abilities
J	Joints	Participating in exercise and physical sports
K	Kum and go	Independent walking, standing or wheelchair moving
L	Labour	Performing work like activities
M	Media	Engaging with media
N	Nod, land of	Sleeping or dozing
O	Own care	Independently engaging in self care
P	Physical care	Receiving practical, physical personal care
R	Religion	Participating in religious activity
S	Sex	Activity related to explicit sexual expression
T	Timalation	Direct engagement of the senses
U	Unresponded	Communication without receiving a response
W	Withstanding	Repetitive self stimulation
X	X-cretion	Episodes related to excretion
Y	Yourself	Talking to oneself, or an imagined person; hallucination
Z	Zero option	Behaviours that fit no existing category

There are various coding rules that apply to DCM. For example behaviour category codes C, D, K, L, U, W and Y were linked to a 'degeneration rule' whereby over time (usually over 30 minutes) recorded ill-being scores degenerated to a lower score category (even if the observed behaviour remained apparently unchanged). The seven behaviours listed above are indicative of needing human contact and/or recognition of discomfort and the degeneration rule affects ill-being scores over periods of time when residents' needs are neglected.

Two written reports of DCM findings circulated to staff in November 2001 and July 2003.

Field notes made of meetings with staff to present DCM findings and to discuss issues raised (n = 2 meetings per DCM)

Agenda and minutes of activities and social care meetings (n = 4)

Recorded feedback from staff raised through supervision meetings

Data in this cycle were largely determined by the observation and recording activities of DCM and the subsequent recording in field notes of responses made by staff concerning the DCM findings. The subsequent social care and activities group meetings were formally recorded through minutes.

4.4.2.6 Cycle 6: To improve networks and links with other organisations/ services to share and support good practice.

4.4.2.6.1 Summary of issues informing this cycle: isolation of the Home

The transfer of the Home in October 1999 to the acute NHS trust meant new networks needed to be established with the hospital. Findings from the consultation phase indicated that staff felt marginalised and 'forgotten' with a lack of recognition by 'outsiders' of the demands and skills of this care environment.

4.4.2.6.2 Taking action: building networks and raising the profile of the Home

1. Collaboration with Hackney Social Services for older people and the health promotion unit within the local Primary Care Trust to host Hackney Older People's Festival in 2000 and 2001

2. Liaison with a local charity providing complementary therapies for older people resulting in aromatherapy being offered to residents

3. Improved links with local chiropody services and the introduction of a new referral system

4. Stroke support group provided by local charity accessed by residents

5. Regular visits to the nursing home made by the hospital senior executive team

6. Visit by the nurse advisor for older people at the Department of Health

7. The Australian shadow minister for health visited on a study tour of international perspectives on long-term care for older people. Visit arranged through the Department of Health and supported by senior managers

8. Staff meeting the chief nurse for England and Wales

9. Securing a 12 week student consultancy project (1.5 hours per week) for staff focusing on the issues around the transition of residents into the nursing home via contacts at the Tavistock Clinic.

10. The researcher acted as a work based assessor for two staff undertaking post registration educational activities through the University

11. Educational support for staff member undertaking undergraduate programme in gerontological nursing

12. Guidance given to applicant for funding of undergraduate programme in gerontological nursing

13. Assistance and encouragement given to two health care assistants in completing level three National Vocational Qualification in care

14. Support given to two health care assistants wishing to undertake a diploma in nursing

15. Influencing the educational commissioning process to ensure the delivery of educational programmes to meet NHS service needs e.g. establishment of rehabilitation practice course

16. Trust Board presentation on the developments within the nursing home

17. Presentation at the bi-annual Royal College of Nursing gerontological conference on clinical governance initiatives across the medical directorate for older people

18. Poster presentations at two hospital quality award days

19. Oral presentations at the nursing strategy group, the medical sister/charge nurse meeting, the hospital's audit half day event and research and development half day event

20. Article written in collaboration with staff and accepted for publication in an international peer reviewed journal

4.4.2.6.3 Data collection methods used

Records of posters and presentation information

Records of visits and events

Field note records

Most data collected in this cycle were recorded in the researcher's field notes.

4.4.3 Evaluation phase (January 2003-June 2003)

The purpose of the evaluation phase was to collect data from which to measure change over time. A multi-method approach to data collection was used including:

- Nursing Home Monitor II
- Shortened Quality of Interaction Schedule (QUIS)
- Repeat DCM
- Exit interviews

- Field notes

4.4.3.1 Nursing Home Monitor II

Nursing Home Monitor II was used to measure the quality of care being provided to patients at the end of the action phase of the study (see earlier details on page 152)

4.4.3.2 The Shortened Quality of Interaction Schedule (QUIS)

The quality of social interactions between nursing staff and residents at the end of the action phase was measured using the shortened QUIS tool (see earlier details on page 151)

4.4.3.3 DCM

Repeat DCM audit of 13 residents took place in June 2003 (see page 162 for earlier information on data collection via DCM)

4.4.3.4 Exit interviews

A total of 22 semi-structured exit interviews (see appendix on page 275 for exit interview schedule) were held with nursing staff inclusive of 4 nurse managers. With one exception, all interviews were audio taped, and 22 were transcribed and checked for accuracy by the researcher.

4.4.3.5 Field notes

Throughout the reflection phase, field notes were kept by the researcher as a daily record of events. Entries were made regarding summaries of exit interviews and informal discussions following these.

4.4.4 Data analysis

4.4.4.1 Qualitative data

Field notes and interviews and focus group data were thematically analysed using an approach which incorporated aspects of those suggested by Coghlan and Brannick (2001) and Morse and Field (1996). The following process was used:

Repeated reading of field notes and interview transcripts, and repeated listening to audiotapes, to allow familiarity with the data to be obtained

1. Application of codes to the data

2. Grouping of similar codes under broader categories.

3. Linking of categories through the identification of common emerging themes

Identifying the inter level dynamics within the system and the significant patterns of relationships between residents/individuals, teams, interdepartmental groups the organisation and community.

4.4.4.2 Quantitative data

Nursing Home Monitor II, QUIS, and other structured audits were analysed using basic descriptive statistics.

4.4.5 Validity and generalisability

Validity and generalisability in action research is contentious, particularly if this is considered from a positivist research paradigm. However, as Bradbury and Reason (2001) state there is a need to be:

> "shifting the dialogue about validity from a concern with the idealist questions of 'Truth' to concern with engagement, dialogue, pragmatic outcomes and an emergent and reflexive stance on what is important." (Bradbury and Reason, 2001; 447)

A variety of processes undertaken as part of the action research study enhanced its validity in the terms described by Bradbury and Reason (2001). Throughout the study the findings, and the researcher's interpretations of them, were continuously fed back to study participants for verification that they were a true reflection of their experience. The regular meetings between the action researcher and staff in clinical supervision provided a forum for dialogue and constant feedback on their experiences. The regularity of supervision sessions allowed relationships with staff to build greater openness on issues and concerns. In addition, through the biographical interviews and the users' and carers' group, residents and family members were supported to voice their issues and offer feedback on the findings and process of research activities. Action learning allowed the

issues and concerns of managers to be discussed and acted upon. Through the three interventions described (clinical supervision, user and carer involvement and action learning) systems were established to build engagement and dialogue with a focus on pragmatic outcomes. These systems enabled participants to 'tell their story' and are the hallmarks of validity in action research (Bradbury and Reason, 2001).

The telling of the story in this action research journey and the contextual information described in the report allows the reader to relate to the material presented in a personal way, drawing upon tacit knowledge (how things are and how people feel about them) and connections with the reader's experience. Robinson & Norris (2001) describe this as 'naturalistic' generalisation which is warranted as all generalisation inevitably involves 'a leap' from the context of investigation to the context of application, which the authors argue is always a leap of judgement and sometimes a leap of faith. This research report seeks to help practitioners understand the project in order to make 'a leap of judgement' as to the applicability of findings in another context.

Prolonged engagement of the researcher with the study areas over 3 years enabled the establishment of trust and rapport with participants, which is considered necessary to enable them to be open and honest within the study process. This was further enhanced through promising and ensuring the confidentiality of data obtained. All reports written and presentations given were checked by participants for accuracy, and permission obtained with participants as to wider dissemination of findings.

The use of multiple methods of data collection, and their integration to support emerging themes, also enhances the validity of the study(Hart & Bond, 1995). Reason and Bradbury (2001), from their perspective on validity in action research, ask whether there is evidence of a plurality of knowing and embracing ways of knowing beyond the intellect. The focus and attention given to feelings and emotional experience in this project set the scene to attend to ways of knowing beyond the intellect. In other words, not just what a participant might think about an issue but also how did the participant feel about the situation.

A rich description of the contexts in which the study took place has been provided which supports naturalistic generalisation. This allows others to identify if the contexts are

similar to their own, and thus if the findings are applicable to their own practice situations. Thus findings have the potential to be generalised outside of this particular study area through the recognition of relevance by individual practitioners. The usefulness and applicability of this project also lies within the policy arena, which advocates the establishment of person-centred care. Organisations and services accessed by older people need to meet the standards laid out in the NSF for Older People and this study is of relevance to people engaged in this major endeavour. Sharp (1998) argues that the generalisability of care study research is often underestimated because of a fundamental confusion over two distinct logical bases upon which generalisations can be made: empirical and theoretical. This study makes no claims on empirical generalisability but will claim theoretical generalisability through the links made to valid theories in the field. Sharp (1998) argues that an in-depth study of a particular case is a fruitful source of theory generation and is a sound and important contribution to research.

Questions of 'validity' in action research need to consider the emergence towards a new and enduring infrastructure (Winter & Munn-Giddings, 2001). Of course, only time will tell if the changes brought about in this project can be sustained. However, at the close of the project there was evidence of a new and enduring infrastructure e.g. re-structuring of continuing care services with greater financial investment in the leadership and management of services and additional therapy input into the nursing home by an occupational therapist and psychologist (for further information see postscript information on page 129). These examples are indicative of the recognition given to sustaining change, bode well for the service's ongoing development and certainly support the validity of this project.

4.4.6 Ethical considerations

Ethical approval for the study was gained from the East London and the City Health Authority (ELCHA) Research Ethics Committee. The local ethics committee gave approval for the project in July 2000. Access to the nursing home was negotiated with the Trust Project Lead (Senior Nurse for Medicine) and the nursing home staff, as were the study proposal and methods to be used. Although it was stated that participation was

voluntary, it needs to be recognised that staff may have felt pressured to participate because of the initial uncertainty associated with the transfer of the Home into the new Trust. This was addressed through individual meetings with ward staff to provide verbal and written information about the study and explore any concerns they may have had. For the purposes of this project gaining consent was seen as a continuous process throughout the study period. The researcher also stressed that participants could decline to take part in data collection activities at any time. Two staff declined to participate in the study as a whole with one staff member not giving consent to use material discussed in one supervision session.

Residents and family members took part in the study through voluntary participation in response to initial requests by the nursing staff, subsequently followed up by the researcher. Written consent was gained following the provision of verbal and written information and the opportunity to ask questions. They were assured that declining to participate would not affect their care in any way. Posters and information leaflets regarding the study were displayed in the nursing home to inform all patients, visitors and visiting professionals that the project was taking place. For the residents living in the nursing home, the ethical complexities of informed consent were increased by their cognitive and physical disabilities. In such instances written or telephone verbal assent was obtained from family members. This was the case for the majority 76% (n = 16) of those residents interviewed. Whilst assent is recognised as not being legally binding, it was considered best practice. One resident refused to participate and one family member refused to give assent and the resident (non-English speaking) subsequently withdrew her consent in the light of her family member's wishes.

A guiding principle in this project was to respect the biographical information given by residents and their family members, and to allow residents and family members to have control in how this information could be shared with the nursing team. The biographical information collected during the interview was circulated to the resident and family member for approval. Residents and family members were always consulted as to how they wished this information to be recorded and where they wished the information to be stored. On one occasion a resident and family member were prepared to meet for an interview but did not wish a written record to be kept. On three occasions biographical

details were amended in accordance with the wishes of the family member. After each interview, the nurse and/or myself discussed with the resident and/or family member if any parts of the life history discussed should be omitted and not shared with the team.

Anonymity of the nursing home within the Trust could not be obtained as the organisation knew where the study was taking place. However, the confidentiality of raw data was maintained through the use of individual codes as opposed to staff names. All electronic data were stored on the researchers personal computer, with paper copies being stored in a locked filing cabinet accessible only by her. Any reports written were checked by staff to ensure confidentiality had been maintained.

An ethical dilemma of action research is that true informed consent is difficult to obtain, due to the research process working with the realities of practice and because the course of the research will not be fully known at the beginning of a study. The researcher therefore revisited consent procedures with any new method used, as well as working throughout the study within the 'principles of procedure for action research' ethical framework outlined by Winter and Munn-Giddings (2001). See appendix three on page 279 for details of the principles of this procedure.

4.5 Findings

For clarity and simplicity the findings of the project will be told in relation to the three phases of the project:

- Consultation and exploration phase
- Intervention/action cycles phase
- Evaluation phase

4.5.1 Exploration and consultation phase

This first phase of the project (from January to December 2000) identified the context in which care was taking place, the quality of care being provided and current issues and concerns of participants. The findings led to the development of action cycles to address these concerns. The findings of this phase are divided into four main sections:

- The context of care: environment, service provision, morale and staff support
- Audit findings relating to the quality of care: QUIS and Nursing Home Monitor II
- Person-centred care evaluated around three psychosocial dimensions
- Summary of data informing individual action cycles

4.5.2 Context of care

Key issues emerging regarding the context of care were the environment of care, the service provision, staff morale and staff sickness rates. All these issues will be discussed in detail but need to be considered in light of the transfer of the Home into the acute NHS Trust and uncertainty over the future for staff, residents and family members at this time.

4.5.2.1 Environment of care

The nursing home opened in 1995 and was a relatively new purpose built facility with each resident having his or her own room. Despite modern premises, interview and observation data collected during this first phase suggested that this was an impoverished and de-personalised environment.

Staff reported the need for a rolling programme of decoration, improved ventilation, better systems to control the heating, improved hygiene and cleanliness and an appropriate call bell system. This information was shared through data collected via the audit tool Nursing Home Monitor II. In addition, staff reported inadequate facilities to store drugs/equipment and an insecure and inefficient door entry system to the nursing home. On the first floor of the nursing home staff were concerned that there was no designated nursing office. The telephone was located in the residents' dining room, providing no place for nursing staff to make confidential telephone calls concerning the care of residents. Clinical and household rubbish were reported by staff to be inappropriately left in the corridor beside the lift. One staff reported:

> "When I am on nights, the mice in this place run over my feet – it is really disgusting. They come out at night and there are so many of them. We complain but the mice don't go away. This place is filthy." (Informal discussion with staff member; November 2000)

The researcher's field notes also report the shabby environment, dirty carpets, smells of incontinence, walls in need of decoration, chipped and dirty cutlery/plates, poor hygiene and lack of cleanliness. An example, of the researcher's experience is taken from her field notes:

> "I went to get a resident a cup of tea and opened the kitchen cupboard. I had been told the resident needed to have a beaker. The cupboard was dirty and had very few useful items in it. There was very little for the residents. I was shocked to see that all the beaker tops were chewed, stained and quite horrible. I wondered why nobody complained or at least ordered some new ones. I feel overwhelmed by a sense of apathy." (Field notes: February 28th 2000)

A further field note made after working a late shift in the nursing home also illuminates the sense of depersonalisation:

> "I found the home very depressing that night, as the rooms felt so empty of belongings and devoid of any life. The heat in the place was overwhelming – quite disgusting and the smell is horrible." (Field Notes: June 3rd , 2000)

A resident interviewed during the Nursing Home Monitor II audit also reported the poor hygiene and the dirty carpets. A family member interviewed during the audit reported the following environmental issues:

- The extremely dirty state of the wheelchair – it had not been cleaned for many weeks
- A poorly decorated room
- A favourite picture had not been hung (family member had been told he could not hang it) and had remained on the floor in the room for many months
- A request was made as to whether the family could decorate the resident's room and this had been turned down

There was a teaching/resource room, but this was small and could only sit one staff member. There was no other allocated space for educational purposes and any scheduled teaching activities took place in one of the resident's lounges.

The main resident's activity room was a large room on the first floor. This facility had to be used by both non-smokers and smokers. Some non-smoking residents refused to use this room and therefore could not access any planned activities. The gardens at the back of the nursing home were reasonably well kept but seemed little used. There was no garden furniture to encourage residents and family members to go outdoors. Resident lounges seemed largely impersonal with few resources for entertainment except televisions. The researcher's reflection in supervision described the Home as feeling like a 'waiting room for death'.

4.5.2.2 Service provision – transfer to the acute NHS Trust

A key issue facing all participants during the first year of the project lay with the recent transfer of the nursing home in October 1999 to a new organisation. Managerial challenges lay in clarifying and organising the transfer arrangements. Discussions through joint supervision with the Matron of Older People's Services highlighted how much this utilised valuable managerial time. This included extensive negotiation to ensure the finances of the nursing home were secure. Due to the lack of certainty regarding the financial situation, a freeze on recruitment took place with a subsequent heavy usage of agency nurses during the first year.

Over £208,000 was spent on nursing agency costs during this period (approximately 8.36 average whole time equivalents and around 20% of the staffing budget). This compared to approximately £64,000 spent in the year prior to the commencement of the project (1999-2000). Staff raised their concerns over having to constantly orientate new staff, taking them away from residents and adding to their workload. Staff were concerned that agency staff did not know the residents and on some occasions reported feeling anxious over the inadequate supervision of these transient staff.

On transfer to the acute Trust, domestic services were taken over by a private (for profit) cleaning company. The domestic provision appeared very poor. Often there was only one domestic for each floor with cleaners who did not appear to know their responsibilities. Staff reported that frequently there was no domestic in the evenings and the service provision was erratic and unreliable. The service appeared poorly managed and often inadequately supplied with equipment e.g. carpet cleaning equipment broken for many months, not enough hand towels and cleaning fluids. In addition, some domestic staff had changes of role forced upon them (in the light of the recent organisational transfer). For example the 'odd job man' was informed his new job description was to include domestic tasks and these new duties were carried out with reluctance. Nursing staff also undertook laundry and some domestic duties e.g. washing up after meals. Staff felt that these duties took them away from residents. They also resented filling the gaps provided by inadequate domestic services. A staff member reported:

> "I feel burdened by the state of this home, I mean how can you feel proud about your work if the place is dirty." (Informal discussion with a staff member: November 2000)

The service provision of therapists and nurse specialists was limited e.g. no palliative care input. A patient dependency survey carried out by the Matron of Elderly Services recommended access to psychology services due to the high prevalence of cognitive disabilities (68% of residents). Despite belonging to the acute hospital services, staff accessed community nurse specialist services e.g. the tissue viability specialist. This seemed to fragment service provision and did little to build new links and integrate the Home with the main hospital.

I held two consultations with staff in February and June 2000 (total of three hours), which 22 staff attended. A number of areas for development were identified through brain-storming activities by group members (see table 4).

Table 4: Areas for improvement identified by staff in the nursing home

	Issues raised
1.	Better equipment e.g. more hoists
2.	More recreational activities for patients e.g. going away on holiday
3.	Health Care Assistant education – 'responsibility issues'
4.	Working with relatives – how to cope with them
5.	Bereavement – better understanding
6.	Closure of life – improved palliative care
7.	Infection Control – better hand washing
8.	Lots of pressures – feel like being in two or three places at once
9	Clinical supervision – never had it
10.	Performance management – current systems not working
11.	Team working – more open and honest relationships

This 'shopping list' of staff issues gives a flavour of the concerns in the nursing home ranging from some practical and clinical issues e.g. more hoists, to interpersonal and relationship issues e.g. team working.

4.5.2.3 Morale and staff support

During this first year of the research project, motivation and morale appeared very low. Staff reported little or no perceived support from outside the nursing home. Indeed, staff reported negative past experiences of management prior to the transfer of the service:

> "knocked left to right, we were sold badly from the outside, the staff were very demoralised, the bosses from outside had trashed the place, it was bad. There was a lack of trust." (Staff interview 1.3, p.1)

Drawing on their previous experience, staff felt suspicion towards 'out-siders' coming into the home, as this heralded enforced change in which they generally felt undermined:

> "the home has experienced this invasion before from nurse managers, so that put everybody on edge and suspicious of every strange person....they came through and told me the care plans were changed, everything changed to what they wanted. If we needed to change it came from management not from staff." (Staff interview 1.3.1 p. 6)

Within the first two months of the transfer, a senior manager wrote a report highlighting a number of financial and managerial concerns, including issues of over-staffing, inflexibility of service provision, poor cleanliness within the home, environmental problems, security issues, and isolation. In the light of previous experience, the staff reported feeling misjudged, victimised and undermined by outsiders.

In addition, during the first year staff described feeling unwanted and forgotten by the hospital. This was increased by being off site and as one staff member said 'out of sight and out of mind':

> "We got nothing at Christmas, not even a visit on Christmas day and I never even saw a box of biscuits. It was a terrible day. In the past we used to get sent a hamper,

special food and drinks – we got nothing from the hospital." (Informal meeting with staff member: January 2000)

As the year progressed, staff began to feel that managerial promises about proposed improvements had not been kept. There was a lot of scepticism about the transfer to the new hospital with concerns that improvements were not being made. Any initial enthusiasm was subsequently followed by lower morale and motivation:

"We have been told that we do not need to do the laundry and washing up but who on earth is here to do these jobs – it is just promises, promises, promises. Things are going from bad to worse." (Informal discussion with staff member: January 2001)

Morale during this first year of the study was extremely low and worsened during this time. Staff felt uncared for, ignored and pessimistic about future developments. Previous managerial experience of change had been negative and 'out-siders' were perceived as causing trouble and undermining staff. For a staff group with many years of experience within the NHS, I felt that both cynicism and stoicism were rife.

4.5.2.4 Staff sickness

It is perhaps unsurprising that in this milieu of care staff sickness was high. During this first year sickness was 7% for registered nurses and 4% for unregistered nurses with an average of 5.8%[5]. Interestingly, in the year prior to the project commencing (April 99 – March 00) average staff sickness was even higher at 7.1%. These high rates of sickness levels may be influenced by the heavy physical nature of work undertaken particularly in light of the age of the workforce (45% of staff were due to retire within the next five years). However, the uncertainty and concerns for the future of the nursing home in relation to the transfer to a new organisation may also have significantly influenced this high prevalence of sickness.

[5] Local NHS Trust target rate for sickness for clinical staff were rates of less than 4%

4.5.3 Issues relating to the quality of care

As previously discussed two audits were undertaken to formally assess the quality of care during the first year. This section will report on the key findings from both audits. For further information concerning the tools see pages 151-152.

4.5.3.1 Audit findings from the shortened quality of interaction tool (QUIS)

Over the eight observation periods within 48 hours a total of 91 coded interactions were recorded. The 8 observations took place in communal areas between 9.00-19.00 hours.

The findings were as follows:

Positive Social interactions = 9 (10%) e.g. Nurse knocks on door and enters with medication (resident in bed with bed clothes hanging onto the floor from the side of the bed) "Let's see how you are ..... you're hot, do you feel hot? I'll get you breakfast in a minute....I'll open your curtains...its nearly 10 o'clock" (Observation day one 09.38 hours)

Basic Care interactions = 46 (51%) e.g. "Tonight for supper we have sandwiches or would you like something hot – chicken in BBQ sauce?" (Observation day two 18.05)

Neutral interactions = 25 (27%) e.g. Nurse putting plate down in front of resident "That's your food" and then leaving immediately whilst resident inappropriately tries to eats lunch with a knife. (Observation day two 13.12 hours)

Negative interactions = 11 (12%) e.g. With a resident present in his room, two staff discuss daily work allocation "Nobody discussed with me, no, no, they should have discussed with me, I'm not looking after him when you've got....."

(Total observations recorded = 91)

Chart 1: QUIS audit findings representing % of positive social (PS), basic care (BC), neutral (N) and negative (N-) interactions during 8 observations over 48 hours

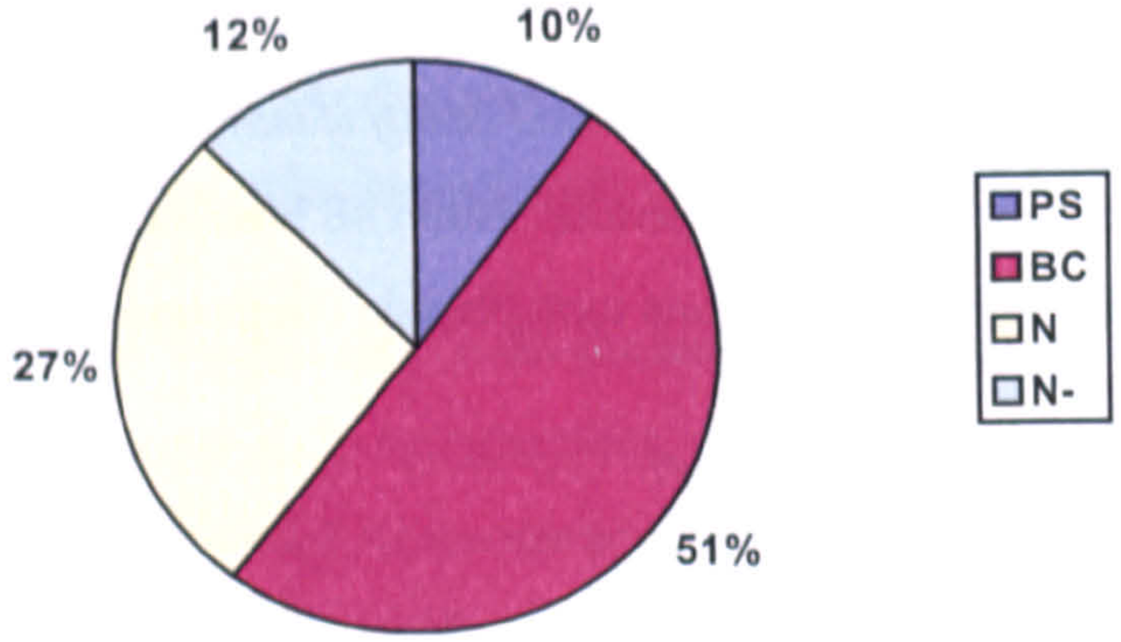
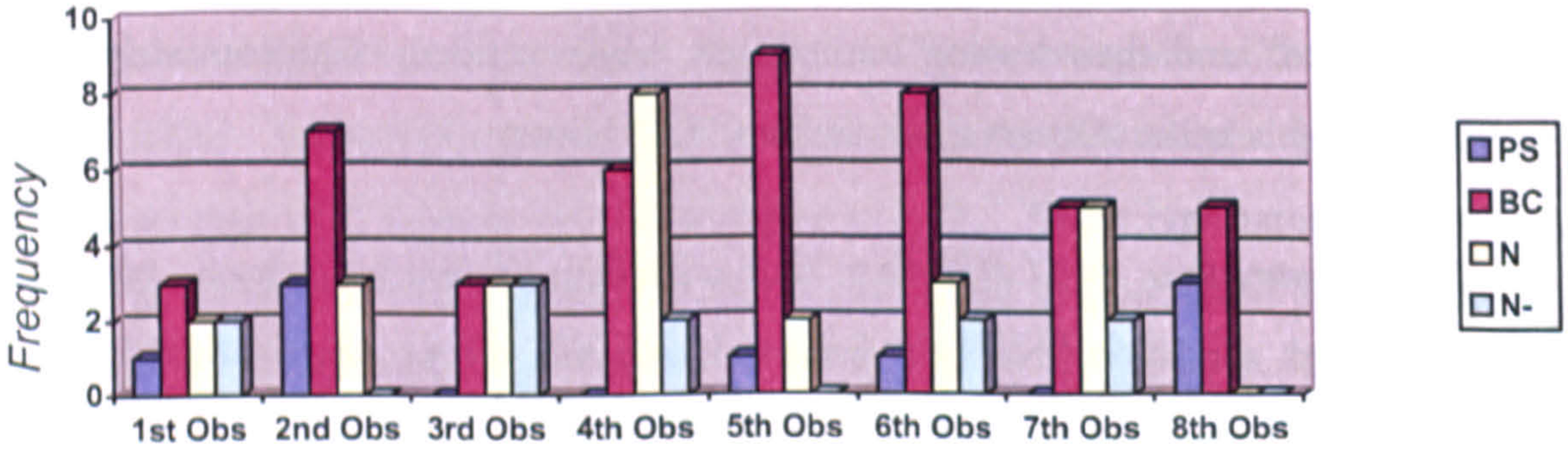


Chart 2: QUIS audit findings representing the frequencies of positive social (PS), basic care (BC), neutral (N) and negative (N-) interactions in each of the 8 observations over the 48 hour period



The first four observations took place on the ground floor of the nursing home. It is evident that the 3rd and 4th observations, made during the afternoon and early evening, had a greater preponderance of neutral and negative interactions, whilst in the morning more positive interactions were observed. This may reflect lower staffing levels in the evening and/or nurses getting tired in the evening due to working 12 hour shifts. However, this pattern was not evident on the second day of observation.

It was encouraging that in total 51% (n = 46) of interactions reached a basic care standard with a further 10% (n = 9) going over and above this level offering residents a positive social interaction (see chart 1). The challenges of caring for residents who are often confused, disorientated and who frequently have communication difficulties means that providing quality care in this field is demanding. However, for every positive social interaction there was a negative interaction (n = 11), where the resident's dignity and respect was negated. Further neutral statements (27%) whereby residents were talked over or largely ignored occurred frequently.

The audit report highlighted the following issues as possible factors influencing the quality of interactions:

- Qualities of clinical leadership, supervision and support
- The practice of extended shifts (long days)
- Valuable nursing time was wasted as hand-overs between shifts were repeated due to a variety of starting and finishing times associated with agency staff usage.

4.5.3.2 Audit findings from Nursing Home Monitor II

The three main sections of the audit tool were used and included home management, patient welfare and nursing care. The care of 20 residents was reviewed during the audit. The overall home management score was 67, which equates to 67% of eligible audit questions on the management of the home being answered positively.

The patient welfare scores were not obtained due to the frailty and cognitive impairment of the residents. This section had 106 closed questions to be answered by residents and when piloted was too long, cumbersome, did little to develop dialogue and seemed undignified as a style of questioning. However, included in this section were open ended questions and these were:

- Can you tell me about what you most about like living here?
- Is there any thing you don't like about living here?

- What can the home and staff do to make life better for you?

Only 4 out of the 20 residents had the cognitive skills and/or physical abilities to answer these questions. The four residents felt staff were the most important part of the quality of care and one resident reported:

> "Like the relationships I have with staff but some nurses do not hear what you want. I pray that they do the right thing. Some people are stubborn but they wash me good." (Monitor interview: October 2000)

Two residents felt that staffing was low in the afternoon and evening. Other concerns raised were the hygiene and poor cleanliness.

Residents reported feeling lonely and bored with little to stimulate them. For example a blind resident said she would appreciate a staff member/volunteer reading to her each day. A family member interviewed during this phase said that the staff seemed unaware of his mother's likes and dislikes e.g. love of jazz and game shows.

The evaluation of nursing care was the largest component of the audit. The following table shows the audit findings of this section.

Table 5: Nursing Home Monitor II baseline audit results

		First Floor			Ground Floor			
	Title	Score	No of Applicable Questions	%	Score	No of Applicable Questions	%	Overall Scores
A	Admission	173	253	68.4	124.5	174	71.6	69.67
B	Care delivered	144	353	40.8	121.5	233	52.1	45.31
C	Medication	67	101	66.3	56	64	87.5	74.55
D	Practical Nursing	224	340	65.9	154.5	214	72.2	68.32
E	Nutrition	48	86	55.8	33	39	84.6	64.80
F	Social Care	57.5	152	37.8	44	134	32.8	35.48

Strengths found in the audit relate to recording admission information and administration of medications. The section on activities, rehabilitation and social care stands out as scoring significantly lower and indicates the greatest scope for development.

The Monitor audit findings highlighted three areas for development:

Communication with other staff groups/families:

1. There was little documentation with regard to communication with families. Additionally, there was little evidence of care planning carried out collaboratively with resident or family member

2. Involvement with the PAMS – very little was recorded in the care plan but instructions for staff were placed on the wall in the resident's room which seemed disrespectful of residents and de-personalised

Clinical practice:

1. No continence assessment tool found to be in use

2. Jugs of water were not available in each room or during meal times

3. Hand washing of residents was limited prior to meals

4. There was poor documentation of self care of residents and it was unclear what residents could achieve

5. Very few goals were identified to promote rehabilitation and maximising independence

Documentation:

There was a lack of documentation about the social side of a person, likes and dislikes, preferred activities

1. Care plans were superficial

2. There was a lack of individuality and no personalisation in care plans

3. There was little emphasis on what residents could do

4. There was a heavy emphasis on physical deficits

5. There was poor evidence of the named nurse keeping the care plan up to date

6. Care plans were disorganised – needed dividers just for ease of reading and quick reference

The summary findings of the audit were presented at a team away-day and through a separate two hour discussion and feedback session with the auditors and nursing home manager. Key issues identified in this latter lively meeting related to the rehabilitation versus social care function of nurses. At the nursing home care was seen as 'restorative' rather than rehabilitation *per se*. The staff reported that the opportunity for activities had decreased over the past five years and to address this decline, further development of social care was seen as a priority. Concerns were raised as to the meagre therapy input and the challenges of providing activities suitable for this client group. The domestic duties undertaken by staff were seen as the main barrier to developing care in this area as large amounts of time was spent on laundry activities.

4.5.4 Person-centred care

Data gained throughout the exploratory phase contributed to a growing understanding of the issues and practice realities of person-centred care. Person-centred care as stated in the NSF for Older People (2001) is as follows:

> "Older people and their carer's should receive person-centred care and services which respect them as individuals and which are arranged around their needs. Older people and their cares have not, however, always been treated with respect or with dignity nor have they been enabled to make informed decisions." (Department of Health, 2001: 8)

The nursing home philosophy of care was certainly congruent with the values identified in the NSF for Older People in advocating individuality, respect and dignity:

> "Quality of life for elderly people requires our recognition of the old person as a unique individual with a need for creative activity, for privacy and fellowship at appropriate times and the right to choose in all matters affecting their health, safety and welfare." (Home nursing philosophy)

However, Kitwood's (1997) concept of person-centred care is based upon knowing the patient and not just the disease. The approach advocates getting to know a patient through understanding their life history and appreciating a person's biography. Kitwood (1997) argues that this is a vital ingredient in providing person-centred care for people with dementia. Utilising biography and collecting life histories was not reflected in the nursing home philosophy. This approach to person-centred care was not part of the conceptualisation of individuality and holism within the nursing home. During this phase, the key issue emerged as to whether Kitwood's (1997) pioneering work utilising biographical approaches in developing person-centred care in the field of dementia care had relevance and applicability to this care setting.

4.5.4.1 The realities of person-centred care

From baseline data collected, gaps could be identified in the provision of person-centred care. The framework advocated by the Pew-Fetzer Task Force (1994) will be adopted in order to consider the findings (see page 103 for earlier discussion). This framework conceptualises three psychosocial dimensions of care:

1. Resident – Practitioner relationships

1. Practitioner – Practitioner relationships

2. Practitioner – Community relationships

4.5.4.2 Resident – Practitioner dimension of psychosocial care/relationships

This section will report findings on relationships between staff, residents and family member/s.

During this exploratory phase, data revealed the main focus of care was on meeting the physical needs of residents. The social, psychological and emotional aspects of care for

people living with chronic illness were inadequately addressed. An excerpt from the field notes reveals the largely physical focus on care:

> "I arrived at 14.00 and we had a very painful handover. It was so depersonalised and focused entirely on physical things done to patients. e.g. no change, incontinent, washed in bed. There seemed to be absolutely no sense of 'ownership' or belonging with the residents or how that resident was feeling that day. There were occasional instructions such as push fluids but the 40 minutes of hand-over consisted of staff mechanically reading through documentation. It felt completely dead, monotonous and exhausting." (Field Note: June 4th 2000)

In addition, audit data revealed a lack of individuality in care planning with a heavy physical focus on care. Qualitative interview data from the Nursing Home Monitor II data revealed that nurses were valued for giving good physical care but the loneliness and boredom experienced by residents was a persistent problem. Staff also identified that there was little stimulation for residents.

As reported on page 180, thirty-nine percent of interpersonal communication observed during the QUIS audit was negative or neutral in quality indicating negation of dignity and respect.

Staff did not identify problematic relationships with residents *per se* but reported encountering difficulties in dealing with family members. During this period, an experienced staff member wept when talking with me over her frustrations and sadness in dealing with a particularly problematic family member. The nurse described the vehement hatred towards staff combined with overt racism. The level of distress created by this family member was extremely severe. Staff described being fearful and dreading the family member's arrival. The nurse gave descriptions of the family member's ability to manipulate staff and how the family member had lied about colleagues. The nurse described the terrible impact on the team. Staff felt systematically abused. There seemed to be a real sense of powerlessness in this situation.

However, whilst working on a shift the researcher noted the following:

> "A distressed family member came looking for a nurse, asking for some help. I went with her and found her Mum on the floor beside the toilet. The resident had fallen whilst her daughter had been helping her on the toilet. I asked if the resident was OK and she said she just needed some assistance to help her off the floor. I said I would get another nurse, when I approached another staff member, she just lifted her eyes to the sky and reluctantly came to help. She said nothing to the family member or resident but just glowered. She told me to help her lift the resident who was now struggling to stand up. I felt she did the lift very roughly. Once the resident was on the toilet the staff member immediately left. The whole interaction was strained and I felt the staff member was rude and her manner offensive. It all felt very unpleasant." (Field note: June 6th 2000)

These two scenarios illustrate the complexities and profound difficulties existing in staff and family relationships during this phase of the project. Indicative of these difficulties, a users and carers group had disbanded and there was no formal forum for users and cares to raise concerns. Patterns of abusive behaviour seemed endemic with a sense of powerlessness to address these issues. Difficult relationships between staff and family members felt entrenched.

4.5.4.3 Practitioner – Practitioner dimensions of psychosocial care/ relationships

This section will report on the findings of relationships between practitioners. This will also include an analysis of relationships established with the researcher during this period. The Pew-Fetzer Task Force (1994) state that:

> "The quality of relationships among members of a service community affects the capacity of everyone within it to form effective relationships with patients and communities." (Pew-Fetzer Task Force, 1994: 35)

This staff group had worked in the NHS for many years (16 staff members having over 20 years experience). Over time many staff had worked together and strong collegial

relationships were established. Staff turnover was low particularly for registered nurses. During the first year, one qualified staff member left the organisation (due to retirement) whilst three care assistants left (two care assistants after periods of sickness; one retired). Staff nurses did recognise the need for 'new blood' but were equally concerned by the nursing shortages and difficulties in recruitment. Such long-standing collegial relationships were felt by the researcher to be a great strength. Staff identified their own strengths as being a stable nursing workforce 'who know the ropes'. They suggested their weakness lay in the monotonous routine, which caused difficulties in motivation and apathy towards making things happen. Certainly, the identification of needing 'new blood' did reflect some stagnation and lack of dynamism in relationships. Staff described feeling tired, exhausted and undervalued by outsiders.

The main problematic issues identified by staff were tensions between registered and unregistered staff. Some unregistered staff felt unsupported by senior staff believing some staff nurses were lazy and did not 'pull their weight'. However, staff nurses said that the unregistered staff did not understand the staff nurse role and the amount of work they had to do. Tensions between these two staff groups were high, with unregistered staff feeling that they had an unequal and unfair share of work. There was a lack of mutual respect between these staff groups.

Relationships with the researcher and practitioners during this exploratory period were characterised by an understandable scepticism. Previous negative experiences with 'outsiders' certainly made establishing trusting relationships difficult for all involved. One staff member reflecting on this phase said:

> "The staff needed to tell you what they had been through. The staff should have had an opportunity to tell their story, to get a feel for what the past five years had been like" (Staff interview 1.3 p.2).

I am a white, relatively young, enthusiastic researcher entering into an environment of experienced and mature black staff. Misgivings were high and evoked comments like 'What is a young high flyer like you doing here?' One staff member's reflection on this period was:

"I thought you would be spying and looking at how we worked...I was very wary and I had my doubts and did not know what was going to happen, I thought you know, I just do not know how to put this but spying will do. Was this about to meddle in our business or stir up trouble? I thought it would go back to the higher people and would have nothing to do with patient care. We were outside the scope of the hospital and they wanted to know what we were doing." (Staff interview 2.4 p.1).

Scepticism by staff as to the 'real' purpose of the researcher may also have been compounded by the fact that the researcher shared an office with the Matron of Elderly Services based at the hospital. This certainly may have compounded any anxiety or mistrust. Difficult feelings of concern about the role of the researcher did not surface during this period. This may have been born out of fear in light of previous experiences and the sense of powerlessness staff had experienced in the face of change in the past. For a project which espoused the values of person-centred care, through getting to know and understand one another, this was a complex and paradoxical start.

During the first year, five supervised meetings took place with the lead nurse of services for older people and the researcher. These meetings met their purpose of exploring the organisational and emotional constraints to changing practice, in line with the systems and psychodynamically informed process of action research being undertaken. This relationship developed well during the first year and I felt supported and valued in my role. The manager gave me freedom to work in a non-hierarchical way with staff and to work with staff and resident agendas.

4.5.4.4 Practitioner – Community dimensions of psychosocial care/ relationships

A significant issue identified during this phase was the relative isolation of the nursing staff from other professional groups or services. The service was experienced by the researcher as being relatively closed with seemingly few connections to the outside world. The staff raised their concerns over fear and mistrust of outsiders due to previous negative experiences.

Besides regular contact with medical services, there appeared to be little energy in building relationships with outside services or organisations. For example, a service less that 200 metres away from the nursing home, providing complementary therapy to older

people was seemingly unknown to staff. There seemed to be very limited networks or links with local churches, community services, voluntary groups and schools. This was illustrated by a notice board for family members with very little up to date information on services and local resources.

However, from demographic data collected during 20 staff exit interviews, 9 (45%) of staff members reported living in the local borough.

From a psychodynamic perspective, the degree of isolation of the Home may be attributed to the difficult human emotions evoked by the residents' dependency, vulnerability and fragility. Human fears of incontinence, 'loosing one's mind', immobility, chronic illness and the immediacy of death may be repugnant, contributing to what I perceived to be a ghetto. Terry (1997) argues very difficult feelings are hidden in the innocuous words of 'continuing care' as the name given to describe this type of environment.

4.5.5 Summary of findings informing individual action cycles

At the close of this exploratory phase (after one year), six areas of practice development emerged and became the action cycles for change in this project. The following is a summary of the findings during this exploratory phase informing each action cycle:

4.5.5.1 Action cycle one: to develop understanding of the lives of residents through sharing biographical information

Summary of key issues informing the action cycle:

1. Resident - practitioner relationships were heavily focused around physical care activities contributing to a de-personalised to approach care. There was an identified need to develop psychosocial care and build resident - practitioner relationships.

2. QUIS audit findings indicated that approximately 40% of observed interactions between staff and residents were poor and did not promote dignity and respect.

3. Nursing Home Monitor II audit findings found care plans lacked information regarding the psychological and social needs of residents

4.5.5.2 Action cycle two: To build staff development and promote learning through clinical supervision

Summary of key issues informing the action cycle:

1. The workforce profile of mature and experienced staff with many years experience in the NHS, who in many cases were not particularly interested in formal education opportunities

2. Staff identified the monotony of the work routine and subsequent apathy this created

3. There was no formal systematic place for reflection and learning in clinical practice

4. Hierarchical and difficult team relationships identified by staff

5. The staff felt decisions had been forced upon from the outside with little sense of their own scope for influencing and owning change

6. There was low morale and the need for staff support

4.5.5.3 Action cycle three: To promote leadership and management development through action learning

Summary of key issues informing the action cycle:

1. Senior managers recognised the pivotal role of effective management and leadership to support change

2. The recent transfer of the nursing home to a new organisation and the Home manager wishing to integrate and build new relationships

3. To build morale and provide support for managers in the older people's services

4.5.5.4 Action cycle four: To foster user and carer involvement

Summary of key issues informing the action cycle:

1. There was no forum for residents and family members to influence change and development

2. There was little evidence in nursing care plans of user and family involvement

3. A previous user and carer group had been discontinued and there was interest from managers in re-establishing a new forum for residents and family members

4.5.5.5 Action cycle five: To evaluate person-centred care through audit (Dementia Care Mapping)

Summary of key issues informing the action cycle:

1. Staff, residents and family members recognised the overly physical focus on care and a desire to see practice change and develop

2. Interest from staff in training to be dementia care mappers in order to evaluate current practices

3. To utilise the DCM tool within a continuing care setting to evaluate person-centred care

4.5.5.6 Action cycle six: To improve networks and links with other organisations/services to share and support good practice

Summary of key issues informing the action cycle:

1. There staff concerns over being a 'forgotten and undervalued' service

2. The need to reduce isolation of the service and establish better links with other health and social care services, community and voluntary organisations

4.5.6 Intervention/action phase

There were six main cycles of research activity for this part of the study and findings from each action cycle will be reported in this section. The phase occurred over two years from January 2001 to December 2002. Staff evaluation of the action cycles was explored during exit interviews at the close of the project. However, for ease of comprehension and to avoid fragmentation of data, their evaluations are included in this findings section.

4.5.6.1 Action Cycle One: Sharing biographical information - findings

Having established in the exploration phase that residents were not being seen in a person-centred way, this action cycle focused on assisting staff to get to know residents better as individuals. Twenty-one residents' life stories were collected over two years. With permission a biographical booklet was written concerning the story told. One family did not want the story 'down on paper'. Two residents and one family member declined to participate.

The biographical interviews undertaken were a powerful process bringing together residents, staff and family members to share a life history. Data collected revealed the following in light of this action cycle and findings will be presented under the following themes:

1. Improved relationships between residents and staff members

2. Improved relationships between staff and family members

3. The need for staff support and skill development in communication and interview skills

4. The need to replicate a similar biographical process for staff

5. Engagement with feelings about loss and death – the process of a 'pre death eulogy'

4.5.6.1.1 Improved relationships between staff and residents

Data collected indicated that staff experienced improved relationships with residents. Staff reported a greater respect for residents as one staff member reported during an interview at the close of the project:

> "I think we have made progress. Before it was just about doing the work but now we are talking with our residents. I think relationships are better and with communication there has been a big shift and now there is respect and now we knock on the doors and we ask if we can borrow things. For example a resident is improving and he is speaking more and as he starts to talk I can understand him more. This is because we are talking to him and we are stimulating him." (Staff interview 2.0 p.2)

The nurse interviewed above described how she had undertaken a biography and how the process had enabled her to start to get in touch with the resident's feelings. She began to see residents in a different light and was more able to be understanding:

> "It was good to have guidelines as there are times when the patient gets depressed or they easily get tired. The process may be to stop and start again. It might not be about getting the information in one go. I understand what makes them sad and if they are in a good mood or a bad mood. We then get a better interaction with staff." (Staff interview 2.0 p.2)

It was recognised by staff that a resident's difficult behaviours would not necessarily change but undertaking a biographical interview could develop greater understanding and insight on that person. A staff member stated:

> "their behaviour is connected to their biography, and talking to their families … their behaviour is connected to their past. There was a lady we used to put to bed, and she would cry and cry and then I sat with her, and just gave her a bit of time. Then I worked out that if a I gave her a pillow case this seemed to settle her. I told my colleagues. Talking to her family, she used to live next door to my Nan, and she used to work in a laundry and this is where the biography helps." (Staff interview 3.4 p.3)

A staff member reported that undertaking a biography helped her to be less fearful of challenging/difficult behaviour:

> "The biography is another thing and now we know our residents and relatives well. They can relate to us. Now, when I first came I was frightened of him, and now he is much better with the biography I got to know him better" (Staff interview 2.4 p.3)

There was evidence of greater emotional involvement and compassion for residents in a culture that traditionally did not support getting attached to residents. However, feelings of attachment did not come without emotional cost as one staff member said in an interview:

> "Relationships have grown during the project. The project has validated special relationships with residents ....yes they have been allowed to grow more. It is like they become part of your family. This makes the death hard – then it hits you like part of your family – it hits you. Colleagues need to understand the loss – over the years she was not just a resident. It is no good saying you must not get attached, when they are ill, the love you feel for them is there and you want to protect them more. Seeing the deterioration..... watching it is heart breaking." (Staff interview 2.1 p.2)

Six residents interviewed reported feeling positively towards the nursing staff and one resident stated that she had a real soft spot for many of the staff. A resident valued knowing staff by name and spoke very fondly of the staff who looked after her. Another resident reported getting accustomed to the staff and that he did not have to put up with having strangers looking after him. He said it was very positive to have a consistent and stable staff group. Another resident said the staff were friendly. A resident reported:

> "everything is alright, I like the nurses, they are alright" (Monitor interview 3.02\auditor SP)

4.5.6.1.2 Improved relationships between staff and family members

Relationships between staff and family members were identified as problematic by both groups at beginning of the project. Over the two year intervention period, data suggested relationships did substantially improve.

Semi-structured interview data with family members (n = 9) and staff (n = 12) at the beginning of the second year of this intervention phase highlighted complex and challenging issues (see interview schedule on page 275). Interestingly, both staff and family members identified each other as being unfriendly and uncooperative at times. Respect and understanding between staff and family members seemed slow to establish.

Family member feedback

From a total of nine interviews, two family members stated that when they arrived at the home they found some staff uncooperative. A family member stated:

> "I feel that care has improved since I first arrived. When I first arrived some of the staff were rude, uncooperative and unhelpful..... now I am good pals with those nurses. At the start it was bad and gradually staff get to know you. However, things seem worse at weekends and it seems more short-staffed. I feel things have got better as there seems to be less usage of agency staff. This is positive." (family member interview: 4)

Another family member reported staff being very shy in coming forward to speak to family members to provide information on how care was going and on the general well-being of the family member. The interviewee felt that much could be done to improve communication and would have really valued a staff member making time to discuss care and to just say 'so and so is doing well, we're doing this and that'. No family member of the nine interviewed reported knowing who was the 'named nurse' or that such a system was in place and who might be the relevant contact nurse for more information.

Staff feedback

From a total of 12 interviews, five staff felt that relationships with family members had improved with one nurse reporting that relationships seem less aggressive. Staff described this as a challenging part of their job and were very keen to see improvements in this area. Nurses wanted family members to be more involved in care. Two nurses felt this was the most important issue needing to be addressed at the nursing home.

Five staff members felt that some family members seemed unfriendly at times and did not seem to be interested in talking with staff. One staff member said that she felt embarrassed asking family members for basics such as soap and toiletries. She said she hoped that when she was old her family would not leave her without the basics. This left her feeling angry. She felt all too often residents were left with too few clothes. She also felt that many family members did not understand that due to incontinence, residents may need a change of clothes a couple of times per day. One nurse reported that she had good personal skills and got along well with family members. Another felt that some family members were very friendly but others would not say hello when you said good morning – there is both good and bad. A staff member reported the new challenges of working with families:

> "it is a new thing in nursing to be close to the family to get them involved with care. Nurses generally think we know best. It is the same with medical people. They don't include the family. But we are being encouraged to do that now, so it is a new thing for us." (Staff interview)

There was no formal system whereby the family members and nurses met to negotiate each other's expectations of care. Additionally, a staff member felt that families needed more reassurance from staff and was concerned this was not given.

The complexity of fostering good relationships with family members should not be under-estimated in this environment. Two participants felt that communication training was needed for staff to help deal with relatives. Certainly, improvements and changes in relationships with family members were identified but staff felt more could be achieved. However, with the exception of staff training, staff seemed unclear on how to progress.

At this mid stage of the project only one staff member considered that a biographical approach may improve relationships with family members.

In the light of the findings of the interviews undertaken at the beginning of the second year of the intervention phase the following activities were established:

- Two workshops for staff on communicating with family members
- Greater staff representation at the user and carer group meetings
- Collection of further evidence to support the funding and recruitment of a psychologist
- Monthly evening 'surgeries' with the manager of the home to meet with family members

At the close of the intervention phase staff did generally associate the biographical approach to changing relationships. One staff member reported:

> "I felt better since I done the biography with him and it helped me a lot better to care for the other residents. When he first came, his son, he would start writing notes to us but since after that biography he was nice and pleasant, right up until now as I got a Christmas card from him ...(laughs). It made lots of change coz you know more about the resident and the family and it was very rewarding." (Interview 3.2 p.1)

However, at the close of the project nearly all of the clinical staff interviewed (n = 18) identified concerns over the lack of involvement and interest in family members in the activities of the home. The staff member stated:

"it is not the residents it is the relatives, I mean in my house there are no families with which to do the biographies with. In my house there is a resident but her family did not want to do it. Another resident, she has nobody and we have two new residents and they do not seem to have family and there is nobody in my group anymore. We have two new residents..... and I have only seen the family once and I have never seen anybody for the other lady. It is OK saying you have the biography but there is

no way you can do it without the relatives and if they are not responding we cannot do it." (Staff interview 3.2 p.3)

This perceived disinterest of family members was defined as the greatest barrier in collecting biographical information particularly when residents were unable to communicate. Although some staff still felt disgruntled with family members, there was recognition of the important role of family members in sharing biographical information particularly for many residents unable to communicate. This stance in identifying the need for involving family members in collecting biographical information, actually represented a substantial shift in the staff's thinking and conceptualisation of family involvement and the potential contribution family members could make.

4.5.6.1.3 The need for staff support and skill development in communication and interview skills

The provision of staff support and skills development over the intervention phase included weekly team supervision sessions, two one-day workshops on person-centred care with 32 staff members attending and two one day communication skills workshops with a total of 28 staff attending. My field notes record some staff feeling very nervous and anxious prior to biographical interviews with residents. Staff felt they needed more training on the person-centred approach to care and suggested ongoing training. One staff member said about the biographical approach to person-centred care and the development of the Home's Getting to Know You biographical tool:

"It does help but we need to be very sensitive in our approach. The approach is very complex and needs sensitivity. I know one staff member who approached a resident and she just did it in the wrong way, and that resident refused, she was not skilled or sensitive enough in her approach.....I am happy about my own sensitive care, but some do not have insight and education here is crucial. We need training in how to use the tool as there assumptions that people can use the tool." (Staff interview 2.6 p.2)

I helped staff to undertake the interviews and was present with a staff member in 19 of the biographical interviews. Towards the close of the project two experienced staff members undertook biographical interviews independently with minimal guidance from the researcher. However, in the main, staff requested support and guidance from the

researcher to help the process. This one to one approach with staff was evaluated positively. However, more formal training on communication and interview skills required for collecting biographical information could have supported developments and certainly should be in place to support ongoing development for the future.

4.5.6.1.4 The need to replicate a similar 'biographical' process for staff

Data collected during the first phase indicated that staff needed to tell their story of what they had experienced at work. Joint supervision discussions with the matron for elderly services identified the need to replicate the biographical process for staff in order to support and embed the process. The provision of team supervision did provide staff with a forum to tell their story of working in this care environment. However, this was also built upon through two induction days run for new staff. Previous induction activities had been didactic with new staff being informed of policies and procedures. In the light of the project, at an induction workshop staff were encouraged to share their own life biographies as well as reviewing policies and procedures. This process was powerful and was evaluated well by the ten participants.

A future recommendation for practice would be to ensure that staff complete the newly devised biographical tool on their own lives to experience using the tool. This could be achieved through training workshops or staff induction activities.

4.5.6.1.5 Engagement with feelings about loss and death – the process of a 'pre death eulogy'

Biographical interviews were generally emotive and frequently participants were upset and tearful. Although the interviews frequently celebrated a resident's life describing childhood, relationships, family and employment, there was inevitable sadness related to the loss of physical and cognitive abilities in old age. During a supervision meeting one staff member described sharing biographical information as being rather like a pre-death eulogy. This was supported by colleagues. Indeed, at least two families used the collected biographical material to help prepare actual funeral eulogies written for residents.

It seemed that the collection of biographical information brought to the surface an awareness of loss and death. There was a striking paradox that through thinking about a person's life, connections were made to the imminence of death and the physical and psychological decline of a person. This was extremely demanding work and staff needed support to work through and understand these processes. The biographical approach is a method of engaging with these very problematic and challenging areas. Managing death and loss is a key component of nursing practice in the field of continuing care (Froggart 2000; Sidell, Katz, & Komaramy, 1997)and the biographical approach to care appeared to assist both staff and family members in dealing with these issues.

4.5.6.2 Action Cycle Two: Clinical supervision - findings

A variety of supervision activities were established during the project. These included team supervision for staff, peer group supervision for the nursing home manager and joint supervision with the matron of elderly services and myself. In addition, I received two-weekly supervision on my facilitation of the staff groups. These activities established a framework across all the hierarchical levels of the continuing care service in which to consider the process of change. Overall, findings indicate that supervision activities helped build openness and develop critical thinking with a more thoughtful approach to practice.

Over the two year intervention phase, the researcher facilitated 104 supervision meetings for two staff teams. Attendance at these supervision meetings was generally good (3-12 members), although not consistent due to the irregular shift patterns worked by staff. A content analysis of the main focus of discussion at each team supervision session is shown in the table below.

Table 6: Main topics discussed at team supervision meetings

Team supervision meetings		
Focus of discussion:	**Frequency**	**%**
Presentation of a life history	21	20
Working with relatives	19	18
Team working	17	16
Death	13	12
Behavioural difficulties of residents	07	07
Environmental issues e.g. cleanliness	05	05
Clinical care	05	05
Activities/psychosocial issues e.g. parties	05	05
Food quality	03	03
Professional accountability	03	03
Review meetings e.g. ground rules	03	03
Changes in elderly care over time	02	2
Child care issues	01	01
Total	104	100

Data from staff interviews (n = 22) and clinical supervision evaluation sessions highlighted four key outcomes of clinical supervision:

- Action and learning in practice
- Support and building morale
- 'Letting off steam'
- Better team working

4.56.2.1 Action and learning in practice

Clinical supervision sessions were seen as a place where staff could raise concerns and consideration was given to any subsequent action that needed to take place. It was generally described in a positive way as one staff member stated: "it was not just talk and talk but we carry out actions" (interview 1.3 p.4). At the close of each session, where appropriate the researcher would agree actions with group members. At the opening of the following session, progress and learning on actions in practice were reviewed. This 'action focus' of clinical supervision was well evaluated by staff and was developed over

time through feedback to the researcher. There was evidence that clinical supervision did bring a fresh perspective on issues followed up by action and as one staff member stated: "it makes me know and it's not just looking at problems but now we discuss and we try some new ways" (interview 2.3 p.2). There was also a sense that clinical supervision did act as a vehicle to support change and development: "as we talked and talked and we did make progress" (interview 2.2 p.3).

Supervision sessions operated in such a way that staff were able to 'see the wood from the trees' and stand back and get a sense of perspective and direction on issues. This helped to reduce fears and anxieties associated with work-based problems. A staff member said the following about clinical supervision:

> "It has been great – we achieved the right path and if you want to bring something up, we know who to bring it up with. From supervision I have learnt how to sort things out through the proper channels. It has helped with the residents as in the case of Jane and her brother says we have given her a punch and through supervision we were able think about what to do and how to manage the brother. We all know where to go and before we did not know where we stood." (Staff interview 3.3 p.3)

This practical work based approach to learning did work for staff particularly those who were near to retirement. One staff member said that due to the imminence of her retirement she was not going to attend any formal educational activities but stated she would always try to attend supervision sessions. She said this was because the sessions were about work-related issues and deemed relevant to her everyday practice. Staff described how some work-related habits 'die hard' but that clinical supervision did help staff reflect and think differently about the routine:

> "Clinical supervision has helped us correct ourselves…some of us still have the idea that at 4 o'clock they (residents) have to go to bed and there really is no reason why they cannot stay up" (Staff interview 2.3 p.3)

The experiential approach to learning offered through clinical supervision was extremely effective for this mature and experienced staff group. An interview with a senior manager stated the project's strength lay in providing 'care for the carers' through

supervision. The process was seen as allowing staff to release their feelings. The manager felt this investment in staff development had resulted in staff delivering better care.

4.5.6.2.2 Support and building morale

Staff interviews revealed that clinical supervision provided support on issues and built morale. Clinical supervision helped staff to feel more secure in their role and built self-esteem and self-respect. It provided a process in which to address morale and depersonalisation. It allowed staff to feel more valued at work. One staff member stated:

> "it has been an eye opener for me – it sort of opened up your eyes to more of what you are actually doing and appreciate what you are doing. When you talk to us, we realise what we are doing in our work and that we are someone as well." (Staff interview 3.5 p.1)

This staff member brings out how she felt 'more human'/less depersonalised in her work place. Clinical supervision worked to support person-centred care by allowing staff to feel valued and respected as people. This was supported by another staff member who reported:

> "And before we had nobody to turn to and you had to stand up for yourself. They just smashed you. There was nobody to fight your own battles. If a relative said something was wrong then there was nobody there for the staff...the relatives were always right. We felt demeaned. We had to fight our own battles. You gave us some support. It has helped me feel like a human being no longer the lowest of the low. With these meetings, if I feel aggrieved I bring it along.... The patients were not responsible – there was just nothing for staff." (Staff interview 3.0 p.2)

Building staff morale, addressing low esteem and depersonalisation amongst staff proved to be the necessary backbone in a project designed to build person-centred care. Clinical supervision acted as a forum in which staff learned to better respect their work and in parallel could better respect themselves. Kitwood (1997), Berg, Hansson, & Hallberg (1994) and Cheston & Bender (1999) argue that in the long term staff cannot provide

person-centred care if they themselves do not feel well treated as human beings and respected in their work. My findings support this hypothesis as support and containment of anxieties in supervision over time allowed some staff to feel less personally attacked and fearful. Over two years clinical supervision fostered more openness and less defensiveness amongst staff. In support of this position one staff member stated:

> "There is an openness to criticism and we have been praised for when we have done something good. We have a different attitude and we are not defensive – there is more objectivity we are not taking it in such a personal way." (Staff interview 2.6 p.4)

Overall, clinical supervision allowed staff to gain greater respect for their work and for themselves. This climate afforded greater openness to feedback and the adoption of a less defensive position. The staff group appeared greatly strengthened by this process.

4.5.6.2.3 'Letting off steam'

Clinical supervision sessions were used by staff as a place to vent frustrations. A wide range of emotions and struggles came to the surface and staff seemed able to effectively use the sessions.

> "It has been a place to express views and feelings. People have let off steam (Staff interview." 2.6 p.4)

A staff member said that if she felt angry then she would attend supervision sessions:

> "Sometimes I just do my crosswords and I just wanted to be on my own. If I felt angry I would attend. Just got to get it out." (Staff interview 3.0 p.2)

However, there were concerns that on occasions supervision became too personal. A staff member stated:

> "If you want to raise an issue or problem then names should not be mentioned, this is not the idea, I mean it is OK to say I am peed off I do this and others do not do this. But people were mentioning names, it does not seem to have put people off, but we need to think about issues as a team." (Staff interview 3.4 p.4)

Two staff raised concerns about senior colleagues. They perceived that if a junior staff member made challenges, a possible consequence would be that the junior would subsequently get given a heavier workload. They felt victimised by some senior members for opening up. Indeed a senior staff member said that at the nursing home:

> "This is a big, big, big issue, particularly for trained staff. This is a very cultural thing - this is about people taking practice development issues and this being seen as a personal attack – this has driven us backwards." (Staff interview 2.6 p.5)

Although staff did let off steam, questioning and challenging practice was risky particularly if some staff members experienced this as feeling personally attacked. A staff member reported: "some staff do not want to say anything as it may go against them" (Staff interview 2.0 p.2). Indeed, there was some evidence as illustrated above that junior staff did not challenge the status quo due to concerns of being 'frozen out' and given a heavier workload.

4.5.6.2.4 Better team working

Staff interviewed felt positive about the role of clinical supervision in building better staff relationships and improving team working. One staff member described how she felt clinical supervision had opened up a door to work with each other better (Staff interview 3.5 p.2). Staff were provided with a group forum and this was effectively used to consider how the teams functioned. Issues such as the allocation of over-time, organising the stocking of cupboards, communication between shifts and staff retirement were all hotly debated. An example below illustrates how working practices were changed:

> "When we do the allocation we just assume that this was alright but when we do clinical supervision, then we realised that it was not working. It was from clinical supervision that now we pair people up and this has helped and this was why there were squabbles and this was very useful." (Staff interview 2.4 p.2)

This example shows how teamwork improved. This was through staff increasingly listening to others and learning to appreciate another's perspective.

4.5.6.3 Cycle three: Action learning - findings

Action learning was provided monthly over two years for eight team leaders in elderly services within acute and mental health services. The manager of the nursing home was a set member over the two years. During the first year, two set members left due to promotion and employment in other organisations. Three learning set evaluations occurred over this time period and these suggested that set members all felt stronger and more confident in their leadership roles.

After the first year of action learning, set members identified the following outcomes from action learning:

- Better management of sickness and absence and poor performance of staff
- Support to establish new work initiatives
- Guidance for staff recently promoted and having to adapt to changes that come with 'big bad manager' role
- Complex issues dissected and dealt with
- Better time management
- Improved working relationships and communication within staff teams.

Evaluation at the close of the first year also established that set members felt committed to the process and wanted to continue for a further year. Evaluations were very positive. Set members reported feeling a growth in confidence and had valued the opportunity of learning together. Sharing problems had reduced isolation in role and supported learning. Set members felt as if they had received honest feedback from colleagues and been helped to answer concerns over 'Did I do it right?' and 'What to do next?' They felt able to give both positive and negative feedback. Action learning had also developed listening skills and challenged preconceived assumptions and ideas. It was also described as 'fun learning' with both a lot of laughter and hard work. Concerns were raised about confidentiality issues in the set particularly over the boundary of the researcher working

'on the ground' in the nursing home and as a facilitator in the set. It was recommended that these boundary issues be given thought during the next year and a system established whereby concerns could be aired at the opening of the ALS meeting.

Evaluation at the close of the second year from all six participants and the two facilitators reflected on the process of two years of action learning. Five staff members had participated for two years and one staff member had been in the set for one year. Both facilitators worked with the set for two years.

The process and outcomes of action learning are thematically presented:

1. Starting out – the unknown
2. Developing and leading teams
3. Personal and professional development
4. Action learning as a guiding light
5. Safe and trusting environment

4.5.6.3.1 Starting out - The Unknown

This method of learning was new for all the set members and set members reported the following:

"I didn't know what to expect from action learning." [M1]

"I initially wondered how action learning could help me." [M1]

"I felt exposed initially and threatened; felt tearful and painful." [M3]

"I didn't know what action learning was initially; was prepared for anything." [M5]

In order to try address concerns, a half-day study day was provided to offer information on the process of action learning and to allow participants to make an informed choice over membership of the set. This experiential style of learning was challenging and an alien way of learning for some set members. This starting point was congruent with

other similar experiential developmental initiatives for clinical nurse leaders in general nursing (Ashburner et al., 2004a).

4.5.6.3.2 Developing and leading teams

Action learning was considered influential in being able to lead and manage teams successfully. One set member stated:

> "I had a fragmented team, but now I'm leading a successful team; patient care has improved, students want to come to my area and we're receiving compliments from patients." [M1].

Another set member reported new approaches in working with her team:

> "... a different way of leading. Now calmer and more patient; less rushing in." [M3]

Attendance at an action learning set was felt to have facilitated development in leadership skills, style and to have influenced closer inter-professional working. Members felt better equipped to manage and problem-solve in their work, and with their teams. One set member stated:

> "I had to learn to listen ... previously impulsive and barge in with solutions; this is now tamed. Used to hear what I wanted ... more able to link into people's emotions. Here and in my team." [M5]

4.5.6.3.3 Professional and personal development: reshaping learning

The process of action learning required emotional energy to relearn and develop leadership skills in practice. The process was challenging but participants felt supported:

> "It has been a new way of learning. I have been unlearning and learning new skills. I feel less defensive. The staff and the organisation have benefited from this. I had to unlearn to learn again. I have to go back and make it happen." [M3]

The action learning set had a role in challenging assumptions and opening up new perspectives on issues. Leadership styles were considered to be more flexible,

understanding and less blinkered and as one participant said: "the process has stretched me; I had preconceived ideas" [M6].

Set members reported feeling anxious over having their practice under the spotlight. They described feeling very uncomfortable at times. However, set members reported very favourably of the support and challenge received from other set members and set facilitators. There was also evidence that the process of action learning supported participants to become more self aware and develop insight into their role:

> "I have been less confrontational with my team ... my bravado has been stripped, seeing more of who I am and seeing staff more as individuals." [M5]

Members generally felt more focused both in their professional and personal lives. Evidence suggests that set members did feel stronger with a greater understanding of their role:

> "Action learning came along as new management role came in; the group helped me come to terms with this new role." [M4]

All of the above descriptions support action learning as a dynamic and powerful process in supporting and reshaping learning for these participants. There was evidence of extensive personal and professional growth by all set members.

4.5.6.3.4 The process of action learning as a guiding light

Action learning provided a forum for 'not getting lost' and as the way forward with problems. This was identified through exploration and reflection with group members:

> "I felt guided. I always thought I was good at managing people until my first presentation. Now I involve my manager when I need support." [M1]

Action learning helped set members focus down, pull back and look at situations from a distance and enabled set members to see the wood from the trees. One set member said:

"Something clicked for me … a veil was removed. I'm seeing more clearly now; see the needs of my team and my ability to help them. Feel they are more empowered to problem solve."'[M5]

Action learning provided managers with the space to develop clarity and insight on problems. It created opportunities for set members to really engage with problematic issues and to act effectively upon them.

4.5.6.3.5 Safe and trusting environment

An important component to this type of leaning is that participants feel both supported and challenged (Brockbank & McGill, 1998). From a psychodynamic perspective this is called emotional containment and is the pre-requisite for effective leadership (Bion1961). A set member felt that:

"the group has been welcoming and friendly; it has been confrontational but not damaging. It has facilitated my growth." [M6]

One member felt she had established good relationships with the group, and would hope to seek support from members outside of an action learning set and I now feel a sense of belonging and trust [M3].

The learning environment established over the two years through action learning was rich and rewarding with set members feeling nurtured to learn and grow.

In summary, Revans (1983) argued that for people and organisations to flourish the rate of learning (L) has to be greater (or equal to) than the rate of change (C) (see earlier discussed on page 123). He advocated action learning as way for managers to achieve this. The development and learning evident from action learning was crucial in supporting the action research process in fostering change and development in clinical practice.

4.5.6.4 Cycle four: User and carer involvement-findings

The main focus of this action cycle was the successful re-establishment of the users and carer's forum, in which residents and family members could raise issues and could influence the running of the home. A group was established called the 'Friends of the Nursing Home' and met on five occasions. A total of 56 relatives and residents attended the meetings with an average of 6 – 12 family and residents at each meeting. There was always a representative from the home management team and the group was predominately chaired by a family member. Outcomes from this group are given below:

4.5.6.4.1 Clinical practice

Chiropody

Concerns were raised by family members about the lack of chiropody services for residents. A new chiropody referral system was established by the manager of the nursing home in collaboration with the chiropody service. Consequently, chiropodists made regular visits and family members and staff reported satisfaction with the new arrangements and the quality of the service.

Therapy services

Concerns were raised about the lack of therapy input for residents. Speech and language therapy and physiotherapy services were considered by family members to be inadequate.

Family members said they wanted advice on how to best position their relatives and guidance in suitable exercises they could help perform. Information was provided on the twice weekly visits made by physiotherapists to the nursing home. In addition, a surgery was offered by the physiotherapist to answer particular issues and teach any appropriate exercises. Encouragement was given for relatives to speak to staff if family members wished a relative to undergo a physiotherapy assessment.

Family members were also worried that residents had little to do except watch television. They described how they would go mad with boredom watching TV all day and that it rots the brain (Minutes of meeting: November 21st 2001). These concerns helped support the case for the appointment of a qualified occupational therapist for the nursing home.

The availability of speech therapy services across the borough was identified as problematic. However, the manager of the home secured a quarterly visit to the nursing home for speech and swallowing assessments to be made. This established a routine service not previously available which was positively received.

Concerns were raised over a referral for a new wheelchair for a resident. This concern was fed back to staff and progress on the referral provided to family members with a subsequent new wheelchair provided.

4.5.6.4.2 Environmental changes

At the family members' request, a new notice board was specifically designated to promote the activities of the 'Friends' group and to share relevant information to visitors to the nursing home. This was described as useful, with up to date information available.

Family members voiced concerns over the delays in improving:

- The door entry system
- The relocation of the activities room
- The designation of a new smoking area

A letter of concern was written on behalf of the membership of the 'Friends' group to the Head of the Facilities Department within the hospital requesting that the improvements be a priority. Within six weeks, these environmental improvements were made.

A family member was concerned over dying fish in an unclean fish tank. The fish tank was subsequently cleaned and the fish removed.

A family member requested easier access to the garden through relocation from the top floor to the ground floor of the nursing home. This took place promptly. A broken washing machine was causing problems for one family member (who liked to wash her mother's clothes on-site) and other family members commented on the lack of reliable dish-washers suggesting they should be replaced. Staff saw these concerns as being

supportive and appreciated these issues being raised by family members. These concerns helped replace dishwashers and repair the washing machine.

4.5.6.4.3 Food Quality

Concerns were raised as to the lack of variety in the menu for residents, the quality of food and the lack of food provided for residents when making an out-patients visit. This was addressed and the following improvements were made:

1. More varied menu planning
2. The introduction of twice weekly 'full English breakfast' with scrambled eggs
3. Liver puree and gammon and pineapple meals discontinued by popular demand
4. Salads and cheese made available on request
5. Softer fruit organised for residents
6. New system in place to serve food on time
7. Ice-cream provided on site
8. Lunch boxes purchased for each floor to be used for packed lunches for residents going for out patients appointments
9. Encouragement of family members in trying a meal and giving feedback on the quality

4.5.6.4.4 Social activities

At group meetings information was shared about social events taking place for residents and family members. A specific 'Friends' party took place in January 2002, followed by a range of parties including the Queen's Jubilee celebrations and a BBQ in September. These events were all positively evaluated by group members with the Jubilee party particularly enjoyed.

4.5.6.4.5 Quality of care

The family and resident feedback over time (a 12 month period) reported considerable improvements made at the nursing home including the standard of cleanliness, the quality of the environment and fewer 'unknown faces' with more regular staff working. They expressed gratitude to staff about the positive changes made.

4.5.6.4.6 Collaboration in directing research activities

This group of users and carers helped me in the development of the action research project. Members assisted in the devising of the biographical tool for use by staff, residents and family members. Feedback from group members helped influence many practical achievements made over the research period. After the first year of the project, I invited family members and residents to devise an interview schedule to evaluate changes (if any) in the quality of care provided. After interviewing 12 residents and family members, in consultation with 'the Friends', they felt I should interview staff to obtain their perspective on the issues raised by interview process. I subsequently went on to interview 12 staff members and a report was circulated to all parties. This mid point project evaluation from residents, family members and staff described some positive changes, particularly in the cleanliness in the Home but noted that the pace of change had been slow. From the 24 participants interviewed, the following changes were recommended to take place over the remaining year of the project:

Family and resident interview feedback (n = 12)

1. One participant wanted to see the introduction of a key worker system because this system would better identify a staff member as responsible for the care of the resident.

2. A kitchenette available for visitors to make tea and coffee, warm-through meals and prepare light snacks

3. To increase the frequency of hair–dressing services and create opportunities for a manicure and pedicure

4. To increase use of the garden area with more patients able to get some fresh air

5. To have more entertainment and activities for residents

6. Increased profile of the manager with regular meetings with family members and residents particularly at the early stages of admission into the Home

7. A photo board of staff members to remind visitors of nurses' names

Staff Interview Feedback (n = 12)

The following areas were raised by staff as areas for improvement and were focused around team working and relationships:

1. Improvement of relationships with family members
2. Communication training particularly focused on dealing with family members
3. Better organisation on the ground floor with fairer allocation of workload
4. Filling the vacant team leader post on the ground floor
5. More effective staff hand-overs on the ground floor
6. Improved transition of residents from the acute hospital – better pre-admission assessment
7. Compulsory attendance at weekly team supervision sessions
8. Fairer allocation of bank work – not just a selected few members of staff
9. Discontinuation of the 11.00-19.00 shift
10. Routine collection of residents' life history information and the development of a Home biographical tool.

Activities identified by staff:

1. Relatives to become more involved with outings and activities.

2. To have more trips out – "nothing happens in the afternoon" – "why don't we take residents out more when the weather is nice?" A suggestion was made that staff could do this on a rota basis

3. To increase the role of the Friends of the Nursing Home

4. To increase outings and entertainment

5. Better organised birthday celebrations

Issues relating to food raised by staff:

1. To have a kitchen on site with discontinuation of cook chill meals

2. There was too much food served at supper – better to offer snacks

Issues relating to maintenance and stocks raised by staff:

1. Better maintenance/replacement of dish washer and hoists

2. Linen to be effectively stocked in resident's cupboards

3. Better supply of hand towels

The findings of the interviews completed with residents, family members and staff were presented to the Trust Board in November 2002.

Interview feedback indicated staff were very positive about the role of the Friends group.

"The carer's group, I know a lot come which is a positive thing and this is good for the improvement of the home. They say things about the home but may be this is good." (Staff interview 2.4 p.5)

"I went to one meeting, it was brilliant, the atmosphere was very positive (Staff interview." 2.6 p.2)

In summary, this group was effective as a forum for promoting resident and family involvement. This was achieved through encouraging residents and family members to share concerns and engage in social activities within the home. The forum was responsive to concerns raised by family members and provided a system for sharing information between staff and family members.

4.5.6.5 Cycle five: DCM (baseline audit) - findings

In November 2001, a Dementia Care Mapping (DCM) audit took place to evaluate the extent to which person-centred care was being delivered. The audit identified major areas for development in fostering person-centred care on each floor of the nursing home. As discussed earlier on page 160 the audit tool provided information on:

- indicators of wellness and ill-being of residents (on a scale of –5 to +5)
- individual behaviours of a resident
- group behaviours

4.5.6.5.1 Ground floor DCM results

The DCM took place over an approximate six hour period from 10.45 until 17.15 on a week day. The audits took place in communal lounge areas. No auditing took place in any personal areas. A total of 8 residents were involved in the mapping process. This audit activity was linked to staff training and development on person-centred care. To re-cap, and for ease of reference please see scores given for well-being and ill-being below.

Wellness and ill-being

Table 7: Wellness and ill-being data (know as WIB scores) in DCM

+5	Exceptional well-being – it is hard to envisage anything better, very high levels of engagement, self expression and social interaction
+3	Considerable signs of well-being; for example in engagement, interaction or initiation of social contact
+1	Coping adequately with the present situation; some contact with others; no signs of ill-being observable

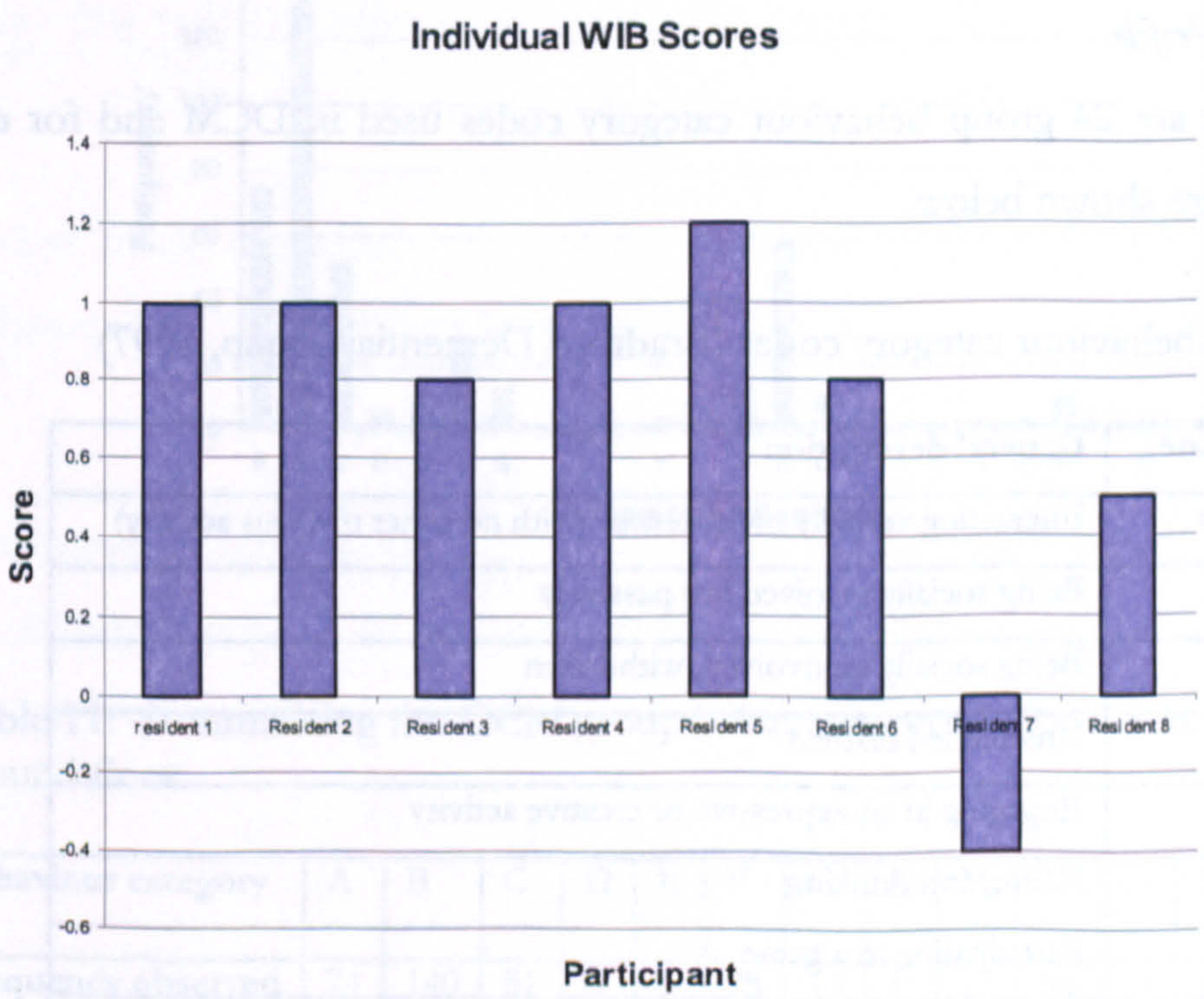
-1	Slight sign of ill-being visible; for example boredom, restlessness or frustration
-3	Considerable ill-being; for example sadness, fear or sustained anger; moving deeper into apathy and withdrawal; continued neglect for over half an hour
-5	Extremes of apathy and withdrawal, rage, grief and despair; continued neglect for over one hour

Table 8: DCM results showing individual WIB scores for residents on the ground floor

Name	Sum of 5 Minute Time Frames	Sum of WIB values	Individual WIB scores
Resident 1	51	49	+1.0
Resident 2	67	69	+1.0
Resident 3	61	49	+0.8
Resident 4	47	45	+1.0
Resident 5	53	61	+1.2
Resident 6	68	54	+0.8
Resident 7	69	-25	-0.4
Resident 8	13	7	+0.5

The total group WIB score = +0.7

Chart 3: DCM results as a bar chart showing individual WIB scores



The negative well-being score of one resident (-0.4) was largely due to distress and discomfort sitting in the wheelchair. This was not picked up on in the morning and subsequently degenerated in the afternoon. No alternative sitting arrangement was offered and this contributed to his low well-being score.

Table 9: DCM results showing group WIB value profile

WIB Values	Number of 5 minute time frames	% of time observed
-5	3	0.7%
-3	14	3.3%
-1	45	10%
+1	334	78%
+3	33	8%
+5	0	0%

Well-being was recorded for 86% of the observation period (6 hours). However, ill-being of residents was observed for 14% of the time and indicated a need for improvement in the current care environment.

Group Behaviour Profile

To re-cap, there are 24 group behaviour category codes used in DCM and for ease of reference these are shown below.

Table 10: DCM behaviour category codes (Bradford Dementia Group, 1997)

Code	Memory Cue	General description
A	Articulation	Interacting verbally or otherwise (with no other obvious activity)
B	Borderline	Being socially involved but passively
C	Cool	Being socially uninvolved, withdrawn
D	Distress	Unattended distress
E	Expression	Engaging in an expressive or creative activity
F	Food	Eating and drinking
G	Games	Participating in a game
H	Handicraft	Participating in a craft activity
I	Intellectual	Activity prioritising the use of intellectual abilities

J	Joints	Participating in exercise and physical sports
K	Kum and go	Independent walking, standing or wheelchair moving
L	Labour	Performing work like activities
M	Media	Engaging with media
N	Nod, land of	Sleeping or dozing
O	Own care	Independently engaging in self care
P	Physical care	Receiving practical, physical personal care
R	Religion	Participating in religious activity
S	Sex	Activity related to explicit sexual expression
T	Timalation	Direct engagement of the senses
U	Unresponded to	Communication without receiving a response
W	Withstanding	Repetitive self stimulation
X	X-cretion	Episodes related to excretion
Y	Yourself	Talking to oneself, or an imagined person; hallucination
Z	Zero option	Behaviours that fit no existing category

Chart 4: showing the DCM behaviour profile for residents on the ground floor

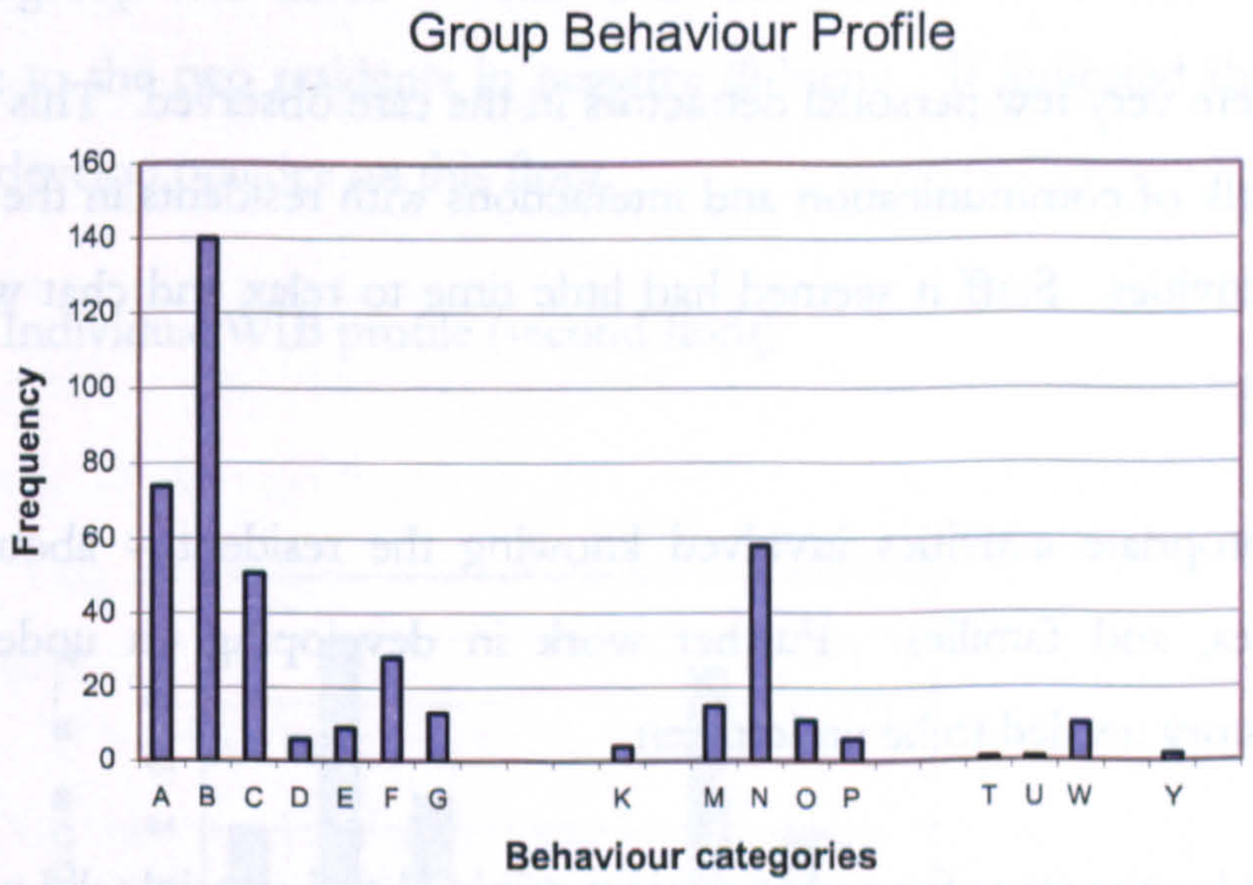


Table 11: Summarising the DCM group behaviour profile for the residents on the ground floor

Behaviour category	A	B	C	D	E	F	G	K	M	N	O	P	T	U	W	Y
Frequency observed	74	140	51	6	9	28	13	4	15	58	11	6	1	1	10	2

The group behaviour profile showed a high prevalence (n = 140 occasions) of borderline behaviour (residents passively engaged with their surroundings). However, this was indicative of a lack of opportunity for engagement and stimulation with consequent boredom and apathy of residents. During the observation period, a staff member asked a resident if she would like to listen to some Elvis Presley and the resident indicated that she would enjoy this. Sadly, the staff member returned saying she could not find an Elvis record. The lounge areas did not have a range of activity materials e.g. newspapers, records, games etc. that staff could easily access these for residents. It is of note that the TV was on fairly continuously but with relatively little engagement or interest from the residents.

The auditors recorded positive events (where well-being was promoted) and personal detractors (behaviours which undermined well-being). All findings were fed back to staff. For example, a recorded positive event involved a staff member communicating with the resident through using a communication board. The staff member told him she liked football and they both chatted about the sport.

Overall, there were very few personal detractors in the care observed. This was positive. However, the bulk of communication and interactions with residents in the main related to direct care activities. Staff it seemed had little time to relax and chat with residents over a cup of tea.

Developing appropriate activities involved knowing the resident – about their lives, interests, hobbies, and families. Further work in developing an understanding of resident's life history needed to be undertaken.

Resources in the lounge areas for activities seem minimal and certainly did not contribute to developing a stimulating, enjoyable and relaxing environment. The challenge ahead for all care staff was to break the tedium and boredom which pervaded the environment.

4.5.6.5.2 DCM results on the Second Floor of the Nursing Home

Data Analysis

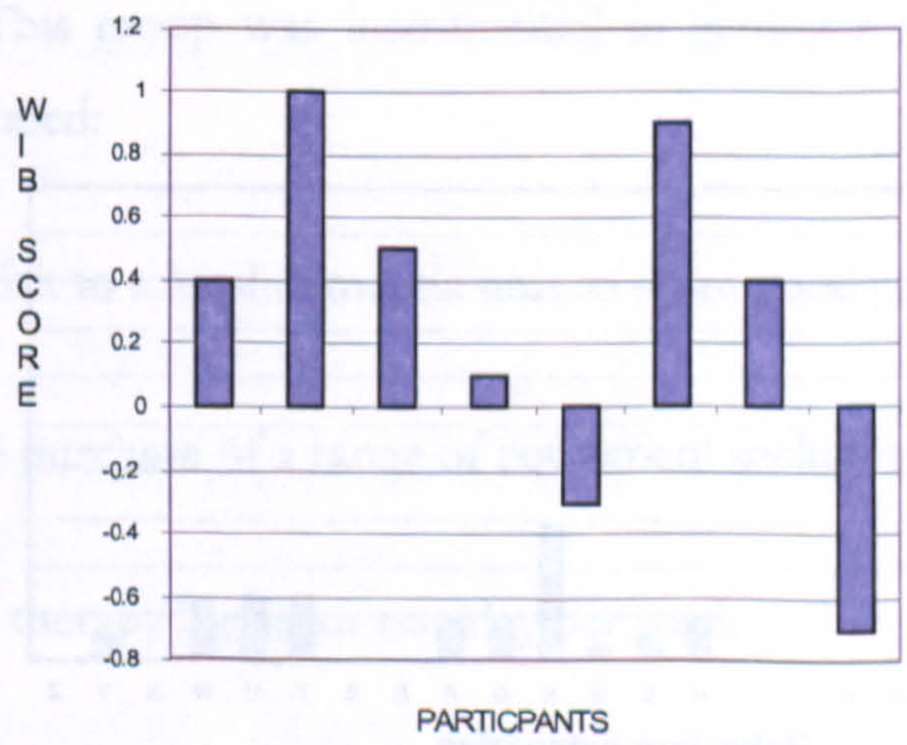
See table overleaf for a summary of the well-being and ill-being scores of eight residents observed during the audit.

Table 12: Individual WIB scores on second floor on the nursing home

Name	Sum of 5 Minute Time Frames	Sum of WIB values	Individual WIB scores
Resident 1	51	22	+0.4
Resident 2	53	51	+1.0
Resident3	50	27	+0.5
Resident 4	26	2	+0.1
Resident 5	65	-17	-0.3
Resident 6	54	46	+0.9
Resident 7	71	25	+0.4
Resident 8	71	-52	-0.7

The total group WIB score = +0.2. This was a lower score than found on the ground floor due to the two residents in negative ill-being. It indicated that there was greater scope to develop practice on this floor.

Chart 5: Individual WIB profile (second floor)



The negative well-being of two residents observed during this audit was largely due to 'cool' behaviours degenerating over time due to a lack of contact from staff. One resident was sitting uncomfortably in a wheelchair and became increasingly distressed as the morning progressed. There was very little stimulation or human contact observed in this lounge for the two residents with negative well-being scores. Mappers commented on their distress observing this situation over time and their feelings of frustration concerning the neglect of residents' needs by colleagues.

Group WIB Value Profile

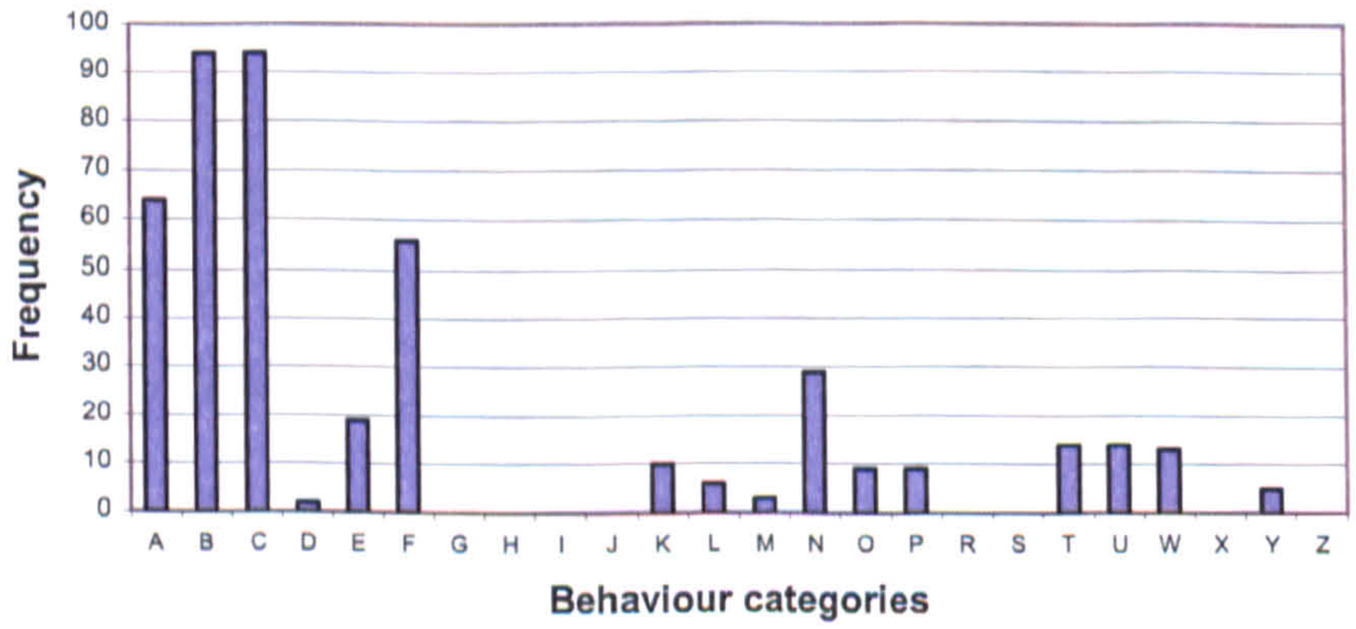
The table below shows how long all participants spent in each of the different WIB values.

Table 13: Group WIB value profile on the second floor

WIB Values	Number of 5 minute time frames	% of time observed
-5	0	0
-3	32	7
-1	135	31
+1	255	58
+3	19	4
+5	0	0

Group Behaviour Profile

Chart 6: Group behaviour profile on the second floor



The group behaviour profile showed a very high prevalence of borderline and cool behaviours, where residents are predominantly passively involved or uninvolved and withdrawn from the social surroundings. The high levels of cool behaviour (socially withdrawn) observed were of concern and indicated the need for greater interpersonal interaction between staff and residents with appropriate stimulation.

Findings were fed back to staff including the positive events recorded and personal detractors. An example of a positive event was when a resident asked about the TV scheduling in the evening and a staff member hunted around the room to find the TV guide. She opened the guide to find the correct date and went through the programming for the evening, picking out with the resident which programme he wanted to watch. She said how much she enjoyed war stories and that it looked to be a good night on the telly. An example of a personal detraction (ignoring) was when a staff member promised two residents a cup of tea and did not return with the drinks. No mid morning drinks were provided for any of the 5 residents in the activity room. Discussions did take place between the residents about how thirsty they felt.

4.5.6.5.3 Outcomes in response to DCM findings

The results from each floor indicated that the most prevalent behaviours involved residents being passively socially uninvolved or withdrawn. This was a cause for concern and led to the establishment of an activities and social care group. This group met in November 2001 for the first time and there were three subsequent meetings during the project. This group was instrumental in getting a range of activities off the ground. These included:

- a visit to a local dementia unit to share good practice on person-centred care
- the purchase of a range of equipment including radios, CD players, games etc
- art therapy input for one day per week
- organisation of a range of social activities including parties, a trip to a local park and museum

- introduction of pet therapy
- contact with a local charity and access to a befriending scheme
- monthly input from an entertainer/singer
- contact with local church groups to provide Sunday services
- staff sharing activities and social care good practice from other nursing homes
- aromatherapy taster sessions for staff and residents
- access to an aromatherapy service for staff and residents

There was no input from a qualified occupational therapist and in light of the DCM findings, recruitment of a qualified occupational therapist (OT) was considered necessary. The DCM findings were a useful lever for change and helped to secure new funding from the occupational health budgets. The OT took up post in January 2003. This post was to support the development of person-centred care. The dementia care mapping process was repeated again in June 2003 and the evaluation phase findings will be reported in the following section.

4.5.6.6 Cycle six: Networks with other organisations - findings

This action cycle set out to address the physical isolation of the nursing home from the hospital and to build local networks with the larger community. A broad range of activities took place including high profile national and international visitors to the nursing home, regular visits from the hospital executive team, links with local charities, presentations at conferences, publications and raising the profile of the Home at hospital events. A twelve week consultancy project was undertaken to consider the transfer of residents into the nursing home. This was led by a student on the Masters programme in organisational consultancy at the Tavistock Clinic as part of the course requirements. Staff were supported to access educational courses e.g. BSc in gerontological nursing, NVQ's. Mentorship and assessment was provided for two staff members in the home

on post-registration courses. Encouragement was given to health care assistants to consider a career in nursing through promoting career open days at the local university.

Staff in the nursing home felt less isolated from their peers in the hospital. This was represented by a staff member saying:

> "before the hospital took over, we were in the shadows, we are part of an organisation and we never had this before" (Staff interview 2.2 p.3).

Another staff member said quite simply:

> "I feel that more people know that we exist here" (Staff interview 4.0 p.3)

Staff reported feeling a growing sense of confidence and respect for themselves and their work. This was expressed in the following way:

> "we are doing well, we have a different model but we address the nitty gritty" (Staff interview 2.6 p.2).

There was an awareness that the research had brought the Home under the scrutiny from the 'outside world' but the service had benefited. The research project had opened doors to the external world. A staff member reported that she felt the researcher's presence had been a catalyst for change:

> "You are an outsider coming in and you are not with us every 24 hours. You can see what we do and if some one complains – then the top brass send somebody in. You write reports and there is good and there is bad but it is like a school, if somewhere is failing, I would expect the Government to do something about it. I would say the project has been helpful" (Staff interview 3.5 p.4)

A manager felt that the nursing home was 'more on the map' in terms of networks with the hospital. However, she was concerned that the nursing home needed to be better linked with other nursing homes. This participant wanted to see the nursing home involved in a nursing home network. This was borne out of concerns that the hospital

nursing service was of a different nature and not in the 'same business'. An action research project across 25 care homes in the region highlighted the isolated and fragmented nature of the care home sector, recommending further extensive development activities in this area (Meehan, Meyer, & Winter, 2002). Networks and collaboration in this sector appeared under-developed with no immediate systems easy to access.

4.5.7 Evaluation Phase

This final phase occurred between December 2002 and July 2003. It included staff interview findings (n = 22), review of organisational performance indicators, a repeat of the baseline audits and dementia care mapping.

4.5.7.1 Interview findings with staff

Twenty-two interviews took place with staff reflecting on their experiences of the project over the three years (appendix on page 275 for interview schedule). Interviews were undertaken with four managers, seven registered staff and eleven unregistered staff. Overall, staff reported feeling happier in the workplace, more motivated, more confident, respected and valued:

> "It has been a breath of fresh air, a life-line, it has brought a bit of life to the home and it has made me see that they are interested in us here and also the carers and relatives." (Staff interview 2.6 p.6)

All staff interviewed felt that there had been improvements and the majority stated that they were feeling happier at work:

> "Skills have come to the surface and I mean my communication skills and my confidence.... it has been about really understanding my work. I am happier in my work this last three years, I have been a lot happier." (Staff interview 3.4 p.4)

The following issues from interview data will be discussed in this section:

1. Expectations of the project – were they met?

2. Evaluation of achievements inclusive of what was not achieved during the project

4.5.7.1.1 Expectations of the project

It seemed that staff had negative, low or few expectations about the project. Research activity was not a process they envisaged would involve them directly. Indeed at the early phases of the project the researcher was seen as a spy that would stir up trouble and make things worse. There was a fear that the researcher had been sent to undermine the

Manager of the Home and that this was the clandestine purpose of the project. However, in negotiating these fears and going forward to see results, these perspectives changed over time and as a staff member stated:

> "Initially I was concerned but now I see the improvement. Now it is smooth but it was bumpy at the start. The turning point was when I saw the change and when I started seeing action." (Interview 2.4 p.6)

The scepticism and fear of the researcher's presence was evoked through previous negative experience of outsiders (see section 4.1.4 for earlier discussion). However, this situation was fuelled by the method by which the project was introduced in the nursing home. This was explained by one staff member saying:

> "This is like your house, then being told you are going to have someone staying in your spare room, like a lodger, whether you like the lodger or not." (Staff interview 1.2 p.2)

There was evidence that at the commencement of the project, there was inadequate clarification of roles that may have helped to allay fears and address the negative expectations:

> "We did not sit down at the beginning with the managers and then we would have realised that there was nothing to fear. But this did not happen ....and we got the cart before the horse." (Staff interview 1.2 p.2)

Another staff member described not knowing what to expect and having limited knowledge of research:

> "We did not know about research before, it has finished too quick. I wish this to continue" (Staff interview 2.3 p.3)

Another staff member described research as an alien activity expecting not to be involved as a junior staff member and went on to say: "I did not think I would be involved but, it has been good to be involved." (Interview 3.3. p.4).

At the end, the research project was seen as highly influential in fostering change and development. A staff member acknowledged her initial scepticism but had been won over when things started to improve:

> "it had been promises, promises, promises, coz we had the researcher here, this made people get their fingers out. It was all about listening without repercussion." (Staff interview 3.0 p.3)

Over time, expectations changed with more positive expectations of the research project:

> "It is better – I mean over a period of time and I have come to be involved and what it actually is…not just me but for everyone." (Staff interview 4.0 p.3)

4.5.7.1.2 Evaluation of project achievements

This section will report findings of both achievements and none/poor achievement identified by staff. The achievements made during this project were diverse. The following categories will be used due to the diversity of achievement and to provide clarity:

1. Environmental improvements
2. Service provision
3. Staff morale
4. Resident - practitioner relationships
5. Practitioner – practitioner relationships
6. Practitioner – community relationships

Environmental improvements

There was a resounding view from all staff interviewed that the cleanliness in the nursing home had improved. This was considered a major achievement that had helped to make the environment a positive one. Staff spoke highly of the room changes (new nursing office, new activities room and smoking room on the ground floor with the relocation of the education room to a larger space). Only one staff member voiced concerns over the relocation of the smoking room onto the ground floor. A resident who enjoyed smoking was afraid to use the lifts to get down to the smoking room. This curbed his enjoyment and the change had been very distressing for him.

Service provision

Staff reported favourably on the new staff recruited and the reduction in agency usage. New staff were seen as bringing fresh ideas in to the home and adding 'new blood' to the team. In addition, the increased quality of domestic services had released staff from many chores. Staff reported that they no longer had to wash and put away laundry and this left more time for residents. Staffing levels were generally seen as adequate and as having greatly improved. However, staff voiced concerns over the 11-7 shift. This shift was unpopular on the grounds that it meant that early shift staff worked with their allocated residents on their own until 11.00. It was described as a barrier to providing person-centred care. This is what one staff member had to say on the issue:

> "Personally, I think you need two staff per house at 7.30 as this is the busiest time. The afternoon is much less busy and we should take staff off the afternoon shift, we have breakfast, we have to dress them and we have to give them lunch. Sometimes some residents are still in bed at 12.00. This could be made better. I have worked in many places and here is the only place I have worked alone. I have always worked as a pair. Some days...we have to strain ourselves if we work alone, I have to use all my force to roll a resident side to side. The residents will be more happy. We need to have pairs in the morning shift." (Staff interview 3.3 p.1)

Morale and staff support

Many staff interviewed reported feeling happier at work and more relaxed as a member of the team. This is what one staff member had to say about the project's achievements:

> "The biographies, clinical supervision, the carers' groups...this has led to a more relaxed atmosphere and an improvement in person-centred care, the cleanliness here and we are more free to talk. We have achieved a lot – so much I cannot really say but communication is good now and the atmosphere is relaxed and when I first came here it was tense." (Staff interview 2.4 p.5)

Clinical supervision was seen as a place for staff to air views and appeared to be particularly significant in raising morale. A staff member reported on the project's achievements:

> "Staff were also boosted during the project and I am personally happier at work. I get support and in the past you were only told if there was a mistake" (Staff interview 2.0 p.3)

Resident – Practitioner Relationships

Staff did report knowing residents better through the biographies and listening to material presented in clinical supervision sessions. They reported staff's growing respect for residents and that staff were more caring and understanding. This represents a significant change and demonstrates the increasing confidence of staff in their relationships with residents and family members:

> "The family and residents are more open and we try to be more open and our residents are excellent and we are more understanding and more caring than we used to be." (Staff interview 3.5 p.3)

Another said:

> "...getting more insight into the person – before we just had information about the period they were sick – now we go back to their childhood, now we know about their

siblings, their life. We come weekly and discuss things and people." (Staff interview 2.1 p.1)

However, there were some concerns that the biographical approach to care was still in its infancy and that real and full ownership was not yet complete. There was optimism "that we will get there" (Staff interview 1.0 p.6) but there was more to be achieved. A barrier to this process was that there was resistance to the approach from some key staff. A senior staff member voiced her frustrations that the biographical approach had not influenced care planning. She felt not enough had been done to emphasise its importance and how the approach could be integrated into the plan of care. This staff member felt there was still a great deal of inertia in getting things into practice. She wondered whether the project should have focused more upon developing senior staff nurses and wondered if this staff group had least benefited from the project's activities. Generally, staff requested more training on person-centred care.

Relationships with family members were described as significantly improving over the study period. Staff felt the 'Friends' group had positively influenced this situation, as well as the support provided through clinical supervision:

"Now there is more communication with relatives, we have opened up a bit more together" (Staff interview 3.4 p.4)

Activities and social care were identified as significantly improved with particular support for the art therapist. However, staff still felt that much more could be achieved in this area.

There was still frustration and anger towards family members from the nurses who felt aggrieved that families were not more involved. Family members were described as having more time for staff and being easier to handle, but as a staff member reported "It is the fact that they do not visit that gets me" (Staff interview 2.1 p.3). This may reflect some cultural differences in experiences of family life:

"Relatives – I just cannot understand it. I think about my grandmother and she was the Queen of the family and I cannot understand why it is so different here – my

> grandparents played a great part in my upbringing and I cannot see how white and black children do not have bonding with their parents. My parents worked and that is not it – I just do not understand." (Staff interview 2.1 p.3)

Staff certainly still experienced some dissatisfaction with their relationships with family members, although it was widely acknowledged that significant improvements had been made.

Practitioner – Practitioner Relationships

Relationships between staff had positively improved during the project. Team working was felt to be stronger, and staff more cooperative and understanding. This helped to build a more relaxed and happy environment. Staff valued working with a steady and consistent workforce. One staff member reported feeling that she had a better understanding of some staff and working with them (Interview 2.1 p.4). All staff groups felt that team working had improved and the comment below exemplifies staff feedback:

> "We never had anything like this before. It has bought a lot and we have achieved a lot and we are more skilled and our team working is much better for the carers (*health care assistants**). I have good relations with other carers. We have more staff now." (Staff interview 3.1 p.3) *my addition

There had been significant improvements in teamwork but staff identified there were two tensions persisting in the teams:

1. Leadership and motivation of staff nurses

2. Old versus new staff

One new member of staff felt that she was allocated a heavier workload and given more demanding residents to care for. She considered this unfair. Other staff were concerned about the practice of working alone and wanted to work as a pair. However, staff's greatest concern was over the lack of leadership and motivation of some senior staff nurses. This was frequently voiced by unregistered staff but was also the view held by some registered colleagues. A sense of inertia and apathy was described about some staff who led and managed shifts. Some staff spoke of their extreme frustration with senior

colleagues who were perceived as not pulling their weight. This tension had improved slightly during the project but persisted as a major concern.

Practitioner – Community Relationships

The main change in this domain of psychosocial care was a more positive view of the 'outside' world in which the nursing home would no longer be seen in a negative way:

> "Relatives tell me about other places and that it is nice here and it does not smell…I see the notice board with 'thank you letters' and this makes me feel good." (Staff interview 4.0 p.3)

Staff described the nursing home as no longer being in the shadows and how they felt recognised as an organisation. There were better links and networks established with the hospital and a range of community and voluntary services e.g. local Churches, a charity for complementary therapies for older people, stroke club, chiropody services etc. However, underpinning these important developments was a more positive outlook to the external world of the nursing home, an openness to criticism and more favourable feedback from visitors. At a presentation made for an open hospital board meeting, a community representative reported having heard of the positive changes in the nursing home from members of a local charity for older people. This was very positive.

4.5.7.2 Organisational performance indictors

The following statistics report on organisational performance indicators in the year prior to the project and over the study period. These include agency nurse usage, staff sickness and staff turnover.

4.5.7.2.1 Agency nurse usage

In the final year of the project, agency usage showed a drastic reduction (see table below). Staff, residents and family members reported favourably on this reduction. Reported benefits lay with permanent staff knowing the residents and routine of the nursing home. This is a vital ingredient in developing person-centred care. In addition, the reduction in agency nurse usage reflected the successful recruitment of staff into vacant posts.

Table 23: Agency nurse usage at the nursing home from 1999-2003

Nursing Home Agency Nurse Usage			
Year	**Agency Cost**		**Average WTE**
99/00	£	64,858.00	2.59
00/01	£	208,906.00	8.36
01/02	£	111,986.00	4.48
02/03	£	2,198.00	.06
Source of data : Management Accounts (April 03) and does not include Bank Usage			

4.5.7.2.2 Staff turnover

Staff turnover is calculated as:

Annualised Turnover = Number of Leavers / Average Staff-In-Post (WTE) x 100

Staff turnover throughout the home is relatively low, particularly for registered nurses (see table below). The average staff turnover across the hospital in 2002-2003 was 16.1%. The highest turnover in the Home was for unregistered staff however, this showed a general reduction in 2002-2003. A stable workforce was in place and this helped to foster person-centred care.

Table 24: Staff turnover from 1999 – 2003

Year	Staff Group	Number of leavers	% Turnover
April 99 – March 00	Registered nurses	1.9	12%
April 00 – March 01	Registered nurses	1	6%
April 01 – March 02	Registered nurses	1.8	11%

April 02 – March 02	Registered nurses	2.8	17.1%
April 99 – March 00	Unregistered nurses	2.6	22%
April 00 – March 01	Unregistered nurses	3	25%
April 01 – March 02	Unregistered nurses	4	19%
April 02 – March 03	Unregistered nurses	3	11.1%

(supplied by the workforce planning department).

4.5.7.2.3 Staff Sickness

Staff sickness is a general indicator of the well-being of the workforce. Overall there were small reductions in staff sickness in the final two years of the project (as compared with the previous two years) for both registered and unregistered staff (see table below). However, staff sickness was higher than the hospital average of 4.8% working days lost in 2002-2003. A factor for consideration was that a substantial majority of sickness was due to long-term ill health. There were two possible factors influencing long term health problems:

1. The physically demanding nature of the work

2. The age profile of the workforce

The workforce was mature and experienced with over 21 staff members (44%) aged over 50 years old. Sixteen (33%) staff members have over 20 years experience of working in the NHS. Sadly, during the study three staff members retired early on grounds of ill health.

Table 25: Staff sickness from 1999 – 2003.

Year	Staff Group	Number of sick days	Number of staff days in period	Sickness %
April 99 – March 00	Registered nurses	362	5840	6%
April 00 – March 01	Registered nurses	456	6205	7%
April 01 – March 02	Registered nurses	294	6205	5%

April 02 – March 03	Registered nurses	344	*	6%
April 99 – March 00	Unregistered nurses	362	4380	8%
April 00 – March 01	Unregistered nurses	166	4380	4%
April 01 – March 02	Unregistered nurses	415	7665	5%
April 02 – March 03	Unregistered nurses	451	*	5%

(supplied by the workforce planning department * indicates data not provided)

4.5.7.2.4 Management and leadership of the nursing home

At the close of the project, a management re-structure was proposed and accepted by staff. The management re-structure was an investment in the leadership and management of continuing care services. The management profile of the nursing home was previously a nursing home manager and one F grade for the top floor and an unfilled F grade vacancy on the ground floor. The new structure recommended a matron for continuing care services managing both the nursing home and a community continuing care service. The matron would manage three G grade nurse managers on each of the floors of the nursing home and in the community service. The community continuing care service would re-locate to the Home with opportunities for greater integration across the teams potentially offering a more integrated service e.g. weekends at home for residents with nursing support. A new F grade post for the management of respite services was proposed. The proposed new structure was a significant investment and gave recognition to the value and developmental progress made in this service.

4.5.7.3 Audit findings

A repeat of the baseline audits was undertaken: QUIS and Nursing Home Monitor II (see earlier information on the tools on pages 151 and 152). This took place in the closing months of the project in early 2003. Both QUIS and Monitor audit tools both

showed positive change and reflected improvements made in the quality care of over the past three years.

4.5.7.3.1 QUIS findings

The shortened quality interaction schedule (QUIS) was used, (eight observations of 15 minutes in communal areas over 48 hours) in which communication between staff, residents and visitors was rated into four categories: negative, neutral, basic care and positively social. Audits were undertaken in December 2000 and January 2003.

In December 2000, from a total of 91 coded interactions, 10% (n = 9) were recorded positively social interactions, 51% (n = 46) basic care interactions, 27% (n = 25) neutral interactions and 12% (n = 11) negative interactions. Whilst the majority of communication was about 'getting the job done' (51%), of concern was the substantial communication (39%) that was found to be poor. However, the challenges of communicating with deaf, confused elderly people often unable to respond verbally should not be under-estimated. In the evaluation phase, this was repeated and significant improvements in the quality of interactions were found. The following table summarises these changes.

Table 14: A comparison in the quality of interaction (QUIS) audit results in December 02 and January 03

Coded interaction	Frequency in December 2000	Frequency in January 2003	% Change
Positive Social interactions	9 (10%)	31 (18%)	+ 8
Basic Care interactions	46 (51%)	126 (74%)	+ 23
Neutral interactions	25 (27%)	13 (8%)	- 19
Negative interactions	11 (12%)	0 (0%)	- 12

Positive social interactions increased by 8%. A higher percentage of communication (74% vs. 51%) was focused around caring activities. No negative social interactions were recorded (a reduction of 12%). In addition, neutral comments were substantially reduced

form 27% to 8%. Interestingly, there was substantially more communication coded in the second audit (170, compared with 91).

4.5.7.3.2 Nursing Home Monitor II – audit findings

Audit findings from Nursing Home Monitor II undertaken in December 2000 and repeated in March 2003 showed positive changes in scores. The table below shows the changes in home management scores. The top score achievable in each category is 100. Each score represents the percentage of eligible audit questions scored positively.

Table 15: Nursing Home Monitor II management scores (December 2000 and March 2003)

	Audit in 2000	Audit in 2003	% change
Ground floor management score	72	84	+12
First floor management score	61	83	+22
Total Home management score	67	84	+17

The following are examples of improvements made over the study period: new carpets/flooring and re-decoration of the home, new nursing office facilities on first floor, new security system, improved call bell system, better supplies for hand washing, improved cleanliness, better storage of equipment, better management of domestic and clinical waste.

Table 16: Nursing Home Monitor II nursing care scores (December 2000 and March 2003)

	Ground Floor: 2000	First Floor: 2000	Home scores in 2000	Ground Floor: 2003	First Floor: 2003	Home scores: in 2003	% change
Admission information	72	68	70	59	63	61	-9
Care delivered: currently applicable	52	41	45	65	63	64	+19
Medication	88	66	75	91	93	91	+16

Practical Nursing	72	66	68	78	72	75	+7
Nutrition	84	56	65	94	76	84	+19
Activities and social care	33	38	35	65	73	69	+34

Table 16 shows improvement in all areas with the exception of information collected on admission. This decrease may be due to the introduction (at the time of the audit in March 2003) of a new format for nursing documentation. This resulted in some admission details being omitted in the transfer of information to the new documentation e.g. medications on admission. However, overall there were positive improvements in all other areas. Most substantial improvement was shown in the delivery of activities and social care for residents e.g. aromatherapy, live entertainment and pet therapy. This tool indicates that there were quality improvements in management and nursing care over the study period.

4.5.7.3.3 Dementia care mapping findings

Repeat dementia care mapping audits took place in June and July 2003. The same audit team repeated activities on both floors of the nursing home. Changes over time for each floor are reported.

Overall, positive changes in resident's well-being and the profiles of group behaviour on each floor were found. These results indicate that both floors had made positive changes towards creating a more person-centred environment. The new occupational therapist shadowed the auditors during the six hour observation. The findings report those changes but also highlight where practice improvements could still be made. Findings are reported in this way as the road to success in person-centred care is always under construction and represents the on-going developmental nature of this project.

DCM results for the ground floor

The DCM took place over an approximate six hour period from 10.10 until 17.00 on a week day in communal lounge/dining areas. A total of 6 residents were involved in the mapping process.

This audit is a repeat of DCM activities undertaken in November 2001. In the first audit in November 2001, 8 residents were observed, whilst in the second audit in June 2003, 6 residents were observed. The numbers of residents selected is random and reflects the usage of the lounge area on that particular day. However, the DCM results showed some improvement in 2003 as compared to the earlier audit in 2001. These improvements are discussed below.

Table 17: Individual ill-being and well-being (WIB) scores in 2003 on the ground floor

Name	Sum of 5 Minute Time Frames	Sum of WIB values	Individual WIB scores
Resident one	60	66	1.1
Resident two	51	13	0.3
Resident three	48	58	1.2
Resident four	50	63	1.3
Resident five	57	59	1.0
Resident six	50	44	.9
Total	**316**	**303**	**-**

The total group WIB score for the audit completed in 2001 = +0.7. The total group WIB score for the audit completed in 2003 = +1.0.

This indicates that the well-being of residents had improved compared to the previous audit. Although five different residents were audited in 2003, this does not negate the findings as DCM records the milieu and evaluates the quality of the environment in influencing well-being or ill-being.

Group WIB Value Profile

The table below shows how long all participants spent in each of the different WIB values in both 2001 and 2003.

Table 18: Group WIB Value Profile in 2001 and 2003 for the ground floor

WIB Values	Number of 5 minute time frames in 2001	Number of 5 minute time frames in 2003	% of time observed in 2001	% of time observed in 2003
-5	3	2	0.7%	.6%
-3	14	2	3.3%	.6%
-1	45	20	10%	6.4%
+1	334	265	78%	83.9%
+3	33	25	8%	7.9%
+5	0	2	0%	.6%
Total	429	316	100	100

This table show that in the second DCM in 2003 greater amounts of time were spent in well-being and less time observed in ill-being. Findings from the 2001 audit showed 14% (n = 62 time frames) of the observation period showed residents in ill-being. In 2003, 7.6% (n = 24 time frames) of the observation period showed residents in ill-being. This is approximately half the recorded ill-being during the first audit. This is a positive achievement and reflects a more person-centred environment with less ill-being experienced by residents.

The second audit in 2003 recorded well-being amongst residents for 92.4% of the observation period (n = 292 time frames). This compares with resident well-being recorded in only 86% (n = 367 of time frames) of the observation period in 2001. This is indicative of a more person-centred environment.

Group Behaviour Profile

For ease of reference for the reader the 24 group behaviour category codes used in DCM are given below.

Table 19: Group Behaviour Profile

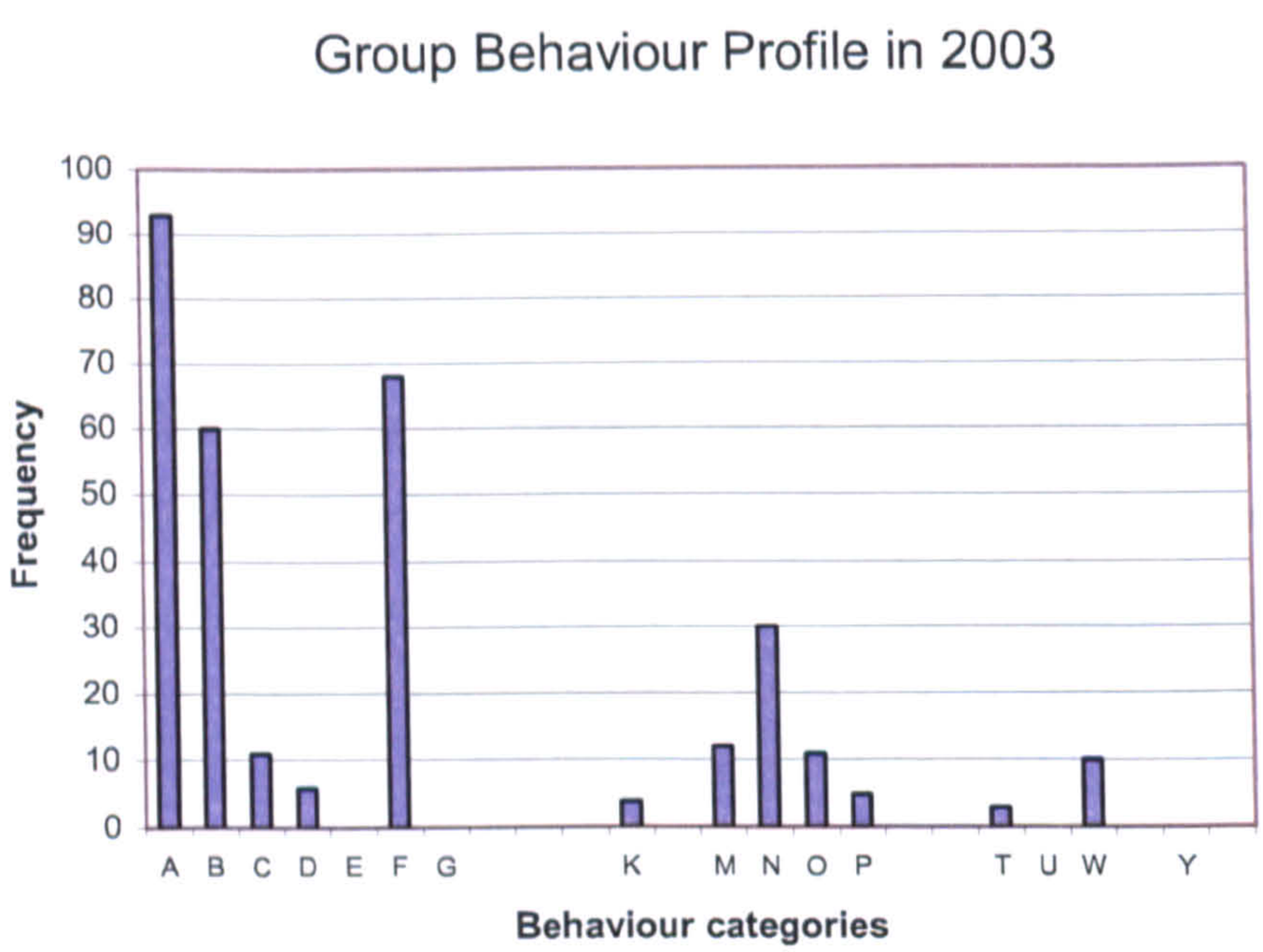
Code	Memory Cue	General description
A	Articulation	Interacting verbally or otherwise (with no other obvious activity)

B	Borderline	Being socially involved but passively
C	Cool	Being socially uninvolved, withdrawn
D	Distress	Unattended distress
E	Expression	Engaging in an expressive or creative activity
F	Food	Eating and drinking
G	Games	Participating in a game
H	Handicraft	Participating in a craft activity
I	Intellectual	Activity prioritising the use of intellectual abilities
J	Joints	Participating in exercise and physical sports
K	Kum and go	Independent walking, standing or wheelchair moving
L	Labour	Performing work like activities
M	Media	Engaging with media
N	Nod, land of	Sleeping or dozing
O	Own care	Independently engaging in self care
P	Physical care	Receiving practical, physical personal care
R	Religion	Participating in religious activity
S	Sex	Activity related to explicit sexual expression
T	Timalation	Direct engagement of the senses
U	Unresponded to	Communication without receiving a response
W	Withstanding	Repetitive self stimulation
X	X-cretion	Episodes related to excretion
Y	Yourself	Talking to oneself, or an imagined person; hallucination
Z	Zero option	Behaviours that fit no existing category

Table 20: Group behaviour profile in 2003 with % of total time observed

Behaviour category	A	B	C	D	E	F	I	K	M	N	O	P	T	U	W
Frequency observed (time frames)	93	60	11	6	0	68	2	4	12	30	11	5	3	1	10
% of observations	29	18	4	2	0	21	.7	1	4	10	4	2	1	.3	3

Chart 6: Showing group behaviour profiles for the ground floor



The most prevalent group behaviour in 2001 was borderline behaviour (passively socially involved- category B) for 33% of time observed (n = 140 time frames). The group behaviour profile in 2003 shows a higher prevalence of verbal interaction (primarily residents chatting and talking with staff and visitors – category A). From a total of 316 five minute time frames, 29% (n = 93) recorded residents talking and chatting with others. This reflects a substantial change and improvement from the earlier audit with more interaction with residents. There was also an 8% decrease in the number of observations of socially withdrawn behaviour (category C). These changes are extremely positive and reflect greater interaction between staff and residents.

In 2003, the third most frequently observed behaviour involved residents eating and drinking (category F). Again the amount of time eating and drinking had increased 14%

and this was an important improvement. This latter activity gave some of the residents a great deal of well-being. However, lunch (the main meal of the day) was served and all over in just 30 minutes. Discussions took place with staff over being less rushed so that opportunities for promoting greater well-being were not missed.

During the observation all residents were frequently offered drinks. This was very positive and represented a substantial improvement on the previous audit. However, current practice was to make drinks in the kitchen. To promote activities and engagement with residents staff discussed making more of an 'elevenses event', with offering morning drinks from a tea-trolley with a range of coffee, teas and biscuits being served.

Category N ('the land of Nod' category) is an interesting behaviour category and the nursing teams gave thought to this as an 'activity'. The residents are elderly and frail and after lunch many of the residents fell asleep uncomfortably in their wheelchairs. Some staff had not previously considered sleep as an 'activity' and how this may be an important part of the resident's day.

Of some concern (negative impact on well-being) was that, of the six residents observed, four residents spent all day in wheelchairs. One resident was sitting in a large recliner chair and another resident offered a chair on arrival in the lounge. However, no offers were made through out the day as to whether residents remaining in wheelchairs wished to be transferred to alternative sitting arrangements. During the six hour observation, one resident requested to go to the toilet and was immediately taken by a staff member. However, no other residents were asked if they would like to go to the toilet during the six hour observation period.

The TV was turned on throughout the observation period. However, only 4% of observations recorded resident's paying attention to this media. A staff member went to buy a resident a paper. Reading the paper gave the resident great satisfaction. Consideration was given as to how residents can access newspapers on a regular basis.

The observation took place in a lounge. Following the feedback, thought was given as to how the lay out of furniture in the lounge might be improved to promote maximum well-

being for all residents. Nearly one third of the lounge area was 'dead space' and used to store walking frames and mobility aids. These items should be stored more appropriately and consideration was given as to how to maximise best use of space. Residents sitting around the perimeter of a room may not create the optimum therapeutic environment.

The resources available in the lounge (besides the TV) had improved since the last audit e.g. a new radio and CD player. However, there seemed to be very few other resources available e.g. coffee table books, magazines, newspapers, large/normal print books, packs of cards.

Summary of improvements shown in DCM findings on the ground floor in 2003:

1. More well-being was experienced by residents audited using DCM in 2003 than in 2001.

2. This resulted in less ill-being recorded in the second audit.

3. The profile of behaviours observed in the second audit reflected greater interaction by residents with others (an increase of 12%).

4. There was a reduction of 8% of socially withdrawn behaviours in 2003.

5. Residents spent 11% more time eating and drinking during the second audit indicating that meal-times were possibly more relaxed.

Recommendations for the ground floor from DCM in 2003:

1. To build on positive changes and take more time over meal times to increase the well-being of residents

2. To consider the timing of meals and ensure the evening meal is not served too early when residents are not hungry

3. To consider making the mid morning drink an 'elevenses event' e.g. a trolley with a range of teas and biscuits

4. To consider the activity of sleeping and ensure residents are offered an afternoon nap

5. To ensure residents are offered an alternative to sitting in a wheelchair all day

6. To review continence management and toileting activities

7. To improve residents' access to daily newspapers

8. To improve resources for residents in lounge areas

9. To consider the layout of the lounge area and inappropriate storage of walking frames etc

10. To complete life history interviews with residents and family members using the 'Getting to Know You' booklet

DCM results on the first floor

This audit (as on the ground floor) was a repeat of DCM activities undertaken in November 2001. In the first audit in November 2001, 8 residents were observed whilst in the second audit in July 2003, 7 residents were observed. The numbers of residents selected was random and reflects the usage of the lounge area on that particular day. Three residents were mapped in both 2001 and 2003.

Table 21: Individual WIB scores

Name	Sum of 5 Minute Time Frames	Sum of WIB values	Individual WIB scores in 2003	Individual WIB scores in 2001
Resident one	70	64	0.9	-
Resident two	62	74	1.2	-
Resident three	29	17	0.6	-
Resident four*	30	30	1.0	-0.3
Resident five	72	-55	-0.8	-
Resident six*	72	40	0.5	0.4

Resident seven*	72	66	0.9	0.9
Total *denotes residents audited in both 2001 and 2003	**407**	**236**		

The total group WIB score for the audit completed in 2001 = +0.2 . The total group WIB score for the audit completed in 2003 = +0.5

This indicates that the well-being of residents has improved compared to the previous audit. Although four new residents were audited in 2003, this does not negate findings as DCM records the milieu and evaluates the quality of the environment in influencing well-being or ill-being.

Group WIB Value Profile

The table below shows how long all participants spent in each of the different WIB values in both 2001 and 2003.

Table 22: Group WIB Value Profile in 2001and 2003

WIB Values	Number of 5 minute time frames in 2001	Number of 5 minute time frames	% of time observed in 2001	% of time observed in 2002
-5	0	2	0	0.5
-3	32	17	7	4.2
-1	135	80	31	19.7
+1	255	276	58	67.8
+3	19	31	4	7.6
+5	0	1	0	.2
Total	**441**	**407**	**100**	**100**

This table shows that in the second DCM in 2003 greater amounts of time were spent in well-being and less time observed in ill-being. Findings from the 2001 audit showed 38% (n = 167 time frames) of the observation period residents spent in ill-being. In 2003, 23.9% (n = 97 time frames) of the observation period was spent by residents in ill-being with a reduction of 14% recorded time frames in ill-being. This is a positive achievement

and reflects a more person-centred environment with less ill-being experienced by residents.

The second audit in 2003 recorded well-being amongst residents for 75.6% of the observation period (n = 308 time frames). This compares with resident well-being recorded in only 62% (n = 274 of time frames) of the observation period in 2001. In 2001 approximately a third of observations were in ill-being and the remaining two thirds in well-being. In 2003, this profile had changed with only approximately a quarter of observed behaviour in ill-being and three quarters of observed behaviour in well-being. This is again indicative of a more person-centred environment but with scope for improvement.

Group Behaviour Profile

See summary on page 245 for 24 group behaviour category codes used in DCM.

Chart 7: Group behaviour profile in 2003

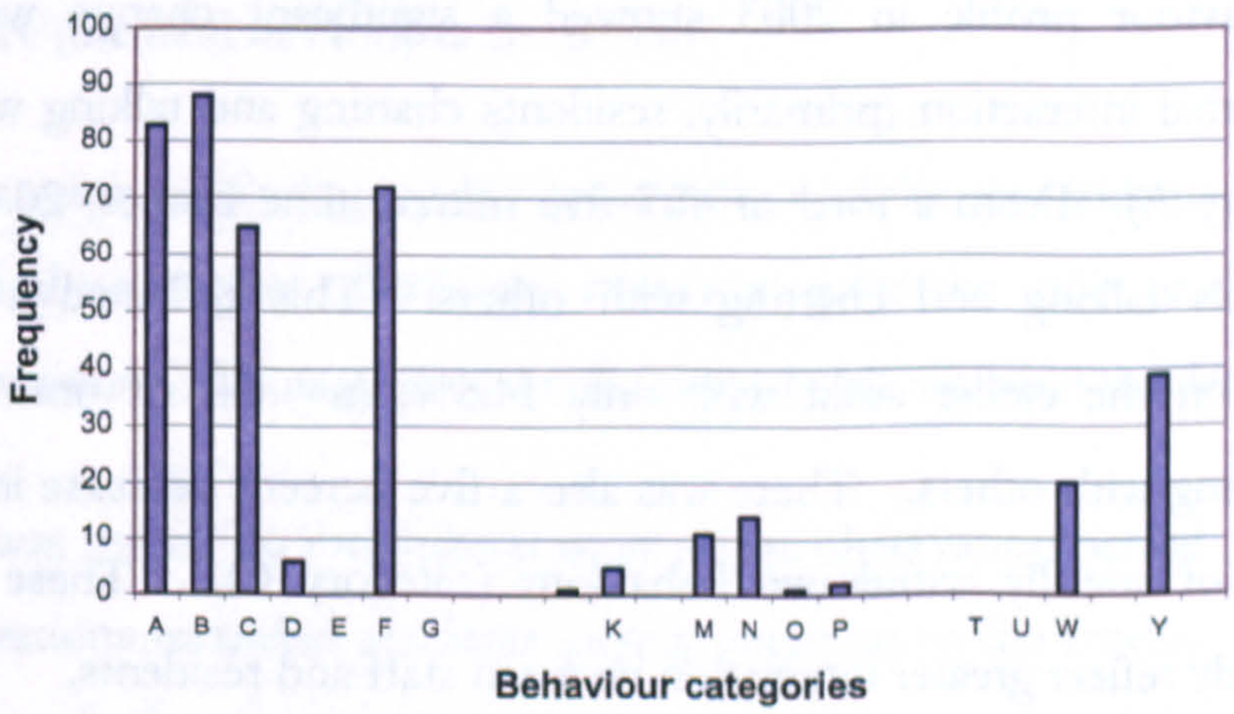
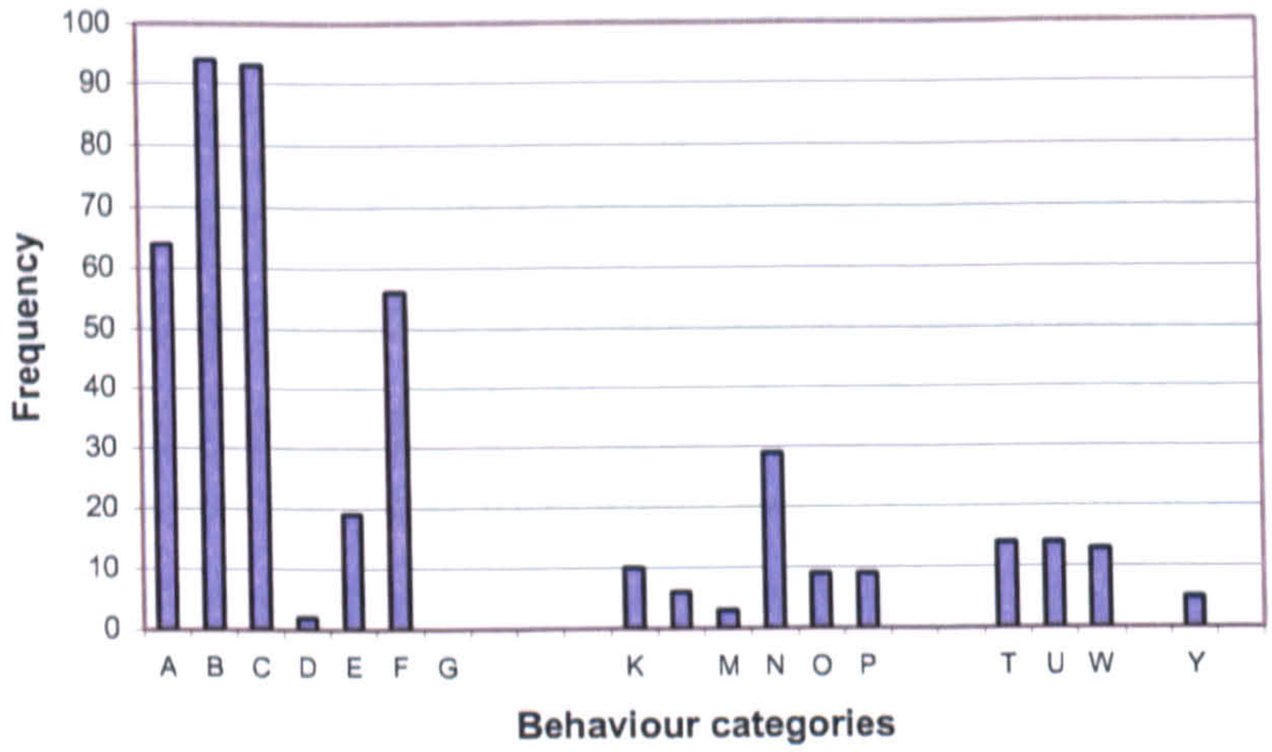


Table 23: Group behaviour profile in 2003

Behaviour category	A	B	C	D	F	J	K	M	N	O	P	W	Y
Frequency observed (5 minute time frames)	83	88	65	6	72	1	5	11	14	1	2	20	39
% of observations	20.4	21.6	15.9	1.6	17.7	0.2	1.2	2.7	3.4	0.2	0.5	4.9	9.7

Chart 8: Group behaviour profile in 2001



The most prevalent groups of behaviour in 2001 were borderline and socially withdrawn behaviour (category B = passively socially involved (n=94 timeframes)) and socially withdrawn behaviour (category C = withdrawn (n= 93 timeframes)). Both behaviours accounted for 42.5% of time observed (n = a total of 187 time frames).

The group behaviour profile in 2003 showed a significant change with a higher prevalence of verbal interaction (primarily, residents chatting and talking with staff and visitors – category A). From a total of 407 five minute time frames, 20.4% (n = 83) recorded residents talking and chatting with others. This reflected a change and improvement from the earlier audit with only 14.5%, (n= 64) of time frames with residents interacting with others. There was also a five percent decrease in the number of observations of socially withdrawn behaviour (category C). These changes are positive and largely reflect greater interaction between staff and residents.

Observations in one lounge showed that as the afternoon progressed contact with resident's decreased and the well-being of one resident in particular degenerated. This resulted in the resident having a negative well-being score. This lack of contact with residents in the afternoon did not occur in the other lounge area and this situation warranted consideration by the nursing teams.

Residents in both lounges spent six hours in their wheelchairs and were observed to be more uncomfortable and restless in the later afternoon. After lunch, offering a change of seating or an afternoon nap may be a way of improving this situation.

In 2003, the third most frequently observed behaviour involved residents eating and drinking (category F). Again the amount of time residents spend eating and drinking had increased 5 percent and was an improvement. This latter activity gave some of the residents a great deal of well-being. A suggestion made by one of the observers was to have table condiments to encourage residents to add salt and pepper to their taste. A positive finding was that lunch was not rushed and residents were given time to enjoy their meal and had a 'change of scene' from the lounge areas.

During the observation all residents were frequently offered drinks. This was very positive and represented a substantial improvement on the previous audit. This staff group suggested making the serving of tea and coffee into a more participatory event.

Again findings of the audit on this floor also revealed that residents were not routinely offered an afternoon nap after lunch. Consideration was given to thinking about category N (the land of Nod) as an 'activity'.

Consistent with the finding on the ground floor, of the six residents observed over the six hour period none were offered the chance to go to the toilet or checked to see if they were incontinent. Discussion and reflection on this situation needed to take place.

The TV was turned on throughout most of the observation period. However, only 2.7% of observations recorded residents paying attention to the media. A personal detractor was observed when in one lounge staff entered the room and discussed turning off the TV. A decision was made to turn off the TV but without any consultation with residents. One resident had been watching tennis at Wimbledon and staff ignored her. No residents were offered or had access to a daily paper. Consideration needed to be given as to how residents can access daily papers on a regular basis.

The observation took place in two lounges and dining rooms. The resources available in the lounge (besides the TV) had improved since the last audit e.g. a new radio and CD player. However, consistent with findings on the ground floor, there were few other resources available e.g. coffee table books, magazines, newspapers, large/normal print books, packs of cards etc. In one lounge area, the shelves were filled with records and yet there was no record player.

Two residents were engaged in category W and Y behaviours (W = repetitive self stimulation and Y = talking to an imagined person). A tray of different objects with different textures and smells may increase the potential for well-being in these behaviours. One resident derived a great deal of well-being from a small doll.

Summary of improvements shown in DCM results in 2003:

1. Greater well-being was experienced by residents audited using DCM in 2003

2. Less ill-being was recorded in the second audit

3. The ratio of ill-being to well-being in 2001 was approximately 1:3, whilst in 2003 this ration had changed to 1:4

4. The profile of behaviours observed in the second audit reflected greater interaction by residents with others

5. There was a five percent reduction of socially withdrawn behaviours in 2003

6. Residents spent five percent more time eating and drinking during the second audit

Recommendations from DCM on the top floor in 2003:

The recommendations were the same as for the ground floor but with the addition of the following:

To involve residents in decision making e.g. the volume of the TV and turning the TV on or off

To consider the layout of the lounge areas with greater use of reclining easy/comfortable chairs

To introduce a tray of objects of varying textures/smells to try to increase well-being for those residents who repetitively self stimulate

4.5.7.4 Summary

This was a complex project trying to develop person-centred care. There was evidence from staff interviews, organisational performance indicators and audit findings that the quality of care did improve. One staff member with over twenty years experience in the NHS reported on the project:

> "Learning to take some ownership of things and I feel as if I am not tearing my hair out. I am trying to be more reflective – I think this really works and I am trying to meet people at their pace. I am less angry. I like justice and fairness. There is a bit more unity in the home and less anger all round. I have been learning to say what I want." (Staff interview 2.6 p.7)

This powerful quotation by an experienced nurse is indicative of the cultural changes made during the project which may not necessarily be captured by the more quantitative evaluative tools used in this research e.g. DCM. The more qualitative data collected through staff interviews indicated resident biographies, clinical supervision and action learning were strong synergistic activities supporting positive change.

4.6 Discussion

The focus of this study has been upon establishing person-centred care in long-term care settings for older people. The study is an example of 'how to' apply a concept to clinical practice through action research. Five topics will be discussed in this section: researcher reflections, a commentary on the usage of audit tools, the broader context and influences on the study, policy initiatives and theoretical ideas and the concept of organisational contagion. These constitute the main areas of debate within this study.

The study resulted in the quality of care improving at the nursing home. There were particular improvements in the quality of interactions between residents and staff and evidence suggests that this care environment became more person-centred. Person-centred care is a complex and amorphous concept, but progress was made in making this a more enriched and less impoverished environment. This was largely achieved by listening to the stories about older people living in the nursing home and to the stories and experiences of staff. In this section of the report factors behind these positive changes will be discussed and the identification of the limitations of the work to date.

4.6.1 The Researcher's reflections

The approach adopted in this study was based upon an action research framework informed by systemic and psychodynamic theory. To work in this way, I had a variety of supervisory systems in place. These systems included supervision with an experienced action researcher and academic in the field. Other supervisory systems included a monthly action learning set. In addition, I had individual supervision on a monthly basis from a psychotherapist and organisational consultant on her group work with research participants. I also met monthly with the senior nurse leading older people's services also met monthly with the same supervisor to explore the interface between the research and managerial agendas. The level of supervision and support was extremely high. This provided the opportunity for plenty of feedback and thinking time related to the development of the project.

This project took two years before changes started to occur in practice. There were a variety of factors that may account for this situation. The first relates to staff members trusting the researcher and her not being seen as a 'spy' for managers. This related to two important issues regarding the establishment of the study in the nursing home. First, senior managers conceived the study as part of the transfer of the nursing home to the new Trust in 1999. It transpired that staff felt they had little control or voice in the decision-making process with subsequent resentment and confusion over the researcher's role. Greater clarification of roles, negotiation and airing of misgivings should have occurred during the first phase of the project. The researcher under-estimated the fears and perceived sense of threat her presence would evoke. However, applying psychodynamic theory to this situation and in particular projective identification processes, it is possible to frame this situation in relation to an enactment of the projections within the institution. The lack of choice and having 'to put up' with decisions may indeed mirror some of the experiences of residents' entering long–term care. In turn staff also had to 'put up with' the researcher and were silent with regard to their concerns and misgivings. The researcher presence was tolerated in silence but misgivings built up to resentment and increasing hostility. This was largely unspoken and finally surfaced after two years. It came about as a formal complaint about the researcher seemingly undermining the manager's role. Despite initially feeling personally attacked, I was able (with support from supervisors and managers) to see how this negativity and anger could be used in a creative and positive way. This complaint represented the first 'real' engagement with the change process (as opposed to 'just putting up with') and out of this situation came some very positive developments. These included a rapid change of pace regarding changes in the home, building trust, stronger managerial presence and a more positive and relaxed atmosphere in the Home.

This pattern of remaining silent (with simultaneously increasing resentment) followed by an angry outburst had a resonance with other patterns of communication in the nursing home. Staff described how families and visitors made angry outbursts towards them, and within supervision sessions staff frequently followed the same pattern towards managers or other team members. Over time the acuteness of these patterns was ameliorated, but they remained a significant behavioural pattern. Drawing on the lessons learnt from the first phase of this project, the importance of issues of negotiation, consultation and

involvement concerning the entry of both staff and residents to the nursing home seem very important to address. Rigorous systems of information, orientation, discussion and exploration of issues should be part of the routine admission to/employment in the nursing home. Transfer and admission processes were not the focus of an action cycle as an established part of the project, but on reflection and 'standing back' from the study this would be an area worthy of consideration in the future.

4.6.2 Commentary on usage of audit tools to evaluate person-centred care

The audit tools used in this study were Nursing Home Monitor II, DCM and QUIS. A brief discussion of the tools' usefulness in developing person-centred care will be made. It is important to emphasis that the approach adopted involved training staff members (registered and unregistered staff members) as co-auditors in all the audits undertaken. This was to ensure the development of audit skills within the teams, to promote ownership of audit findings and to build participatory methods of working. Involvement of staff as co-auditors was powerful as the audit findings were given greater credence and significance when reported by team colleagues. However, the levels of support required to support the auditors was high in helping them 'step out' and evaluate the team's practice. For all the staff involved this was the first time they had been involved in research and undertaken an audit.

4.6.2.1 Nursing Home Monitor II

The main disadvantage with this tool was the time taken to audit 20 residents. This involved a total of three days per auditor for each audit undertaken. It had a heavy focus upon documentation as the measure of the standards of care. The largest problem with this tool was the 100 closed questions for residents on their welfare in the nursing home. This proved to be largely inappropriate for the residents within the nursing home and had to be adapted by the audit team. Instead only open questions were asked about a resident's experience of care, which yielded more useful information than the closed questions. The greatest benefit of utilising the tool was building the relationships between the researcher and auditors and thoroughly reviewing documented care.

However, the tool seemed cumbersome and repetitive due to its 'yes or no' scoring system. Despite these frustrations Monitor did serve to show increases in the quality of nursing care (largely through documentation) as a pre and post evaluation measure.

4.6.2.2DCM

This is a well established tool to evaluate person-centred care for people with dementia. The tool was useful and relevant to the care for older people in long term care not just those living with dementia. However, the main problem with this tool lay in the training of the auditors. Three staff undertook the three-day basic DCM course at Bradford University in 2001. Unfortunately all three failed the examination at the end of the course in order to qualify as trained DCM mappers. This was an undermining experience for all the participants. Fortunately, two staff members attempted the 're-sit' paper and managed to pass several weeks later. Whilst the researcher appreciates the rigour of the DCM training to ensure reliability and validity of the tool, this was a serious blow for all concerned and reflects the determination and dedication of staff to 're-sit'. However, this process came at time in the project when staff felt exposed and vulnerable to the presence of the researcher and the DCM course seemed to highlight the sense of 'failure'. For the researcher it highlighted the long journey ahead in developing practice and the very high levels of support required by staff. On reflection a simpler audit tool may have been more effective in supporting change. An alternative tool evaluating resident well-being alone may have been more appropriate. Bruce (2000) describes a tool where staff evaluate resident well-being and ill-being with a more direct application into care planning activities. This tool may have been inclusive of more staff (as opposed to three DCM mappers) and may have had a more direct impact on the care planning process and everyday care activities. In addition, well-being and ill-being profiling does not necessarily involve 'a one-off' audit approach. It could have been more effectively integrated into everyday care. Bruce (2000) developed the well-being and ill-being profile out of the DCM tool and on reflection this simpler and more user–friendly tool may have been more effective in supporting person-centred care development. The weakness with the simpler tool is that it is less rigorous and from a research perspective does not have the validity or reliability of DCM.

4.6.2.3 QUIS

From the three audit tools used within the study, QUIS appeared the most useful in supporting change. This tool was the most user friendly to staff members and the four rating scales of interaction quality (negative, neutral, basic care, positively social) appeared easily understood by participants in the study. Feedback to staff on the findings seemed to have greater impact than DCM and Monitor as audit findings were clearly understood. This tool seemed to have greatest resonance for practitioners and indeed significant improvements were made over time with regard to the quality of interactions.

4.6.3 The broader context and influences on this study

This study took place from 2000-2003 when the Labour Government expectations of the performance of NHS came under great scrutiny (Ahmad & Broussine, 2003). Quality and performance targets became the mantra of NHS managers along with an increase in Government expenditure to support changes (Malin, Wilmot, & Manthorpe, 2002). This study took place when the NHS was seen to be 'getting better' and financial resources were increasing (Department of Health, 2000). Additional funding for posts e.g. a psychologist, occupational therapist, new team leader (G grade) were added to the nursing home staff establishment. How much securing these additional resources came about due to the action research or as part of a general increase in NHS resources is of course difficult to determine. However, resources were invested in continuing care services, which were clinical areas typically renowned for being marginalised and neglected within the NHS (Terry, 1997).

The nursing home was transferred in 1999 into an NHS organisation deemed to be performing well by the Commission for Health Improvement (CHI) and earning a three star rating in 2001 and 2003[6]. The nursing home was part of an NHS Trust being 'rewarded' by the Government for good performance and which was later designated a Foundation NHS Trust in 2004 (one of only ten NHS Trust in the UK). Hence, this study took place within a successful NHS organisation in which the organisational culture, management and leadership were generally evaluated in a positive way.

[6] See www.chi.nhs.uk for summary of CHI assessment procedures

Nevertheless, certain problems of neglect and commitment to areas in crisis were owned by senior nursing managers. The final year of this study in 2003 saw the momentum of the study accelerate, coinciding with much greater managerial involvement from the senior nursing managers. Energy and positive change really started to occur during this phase. It took two years before improvements started to occur. This too can be attributable to the increasing year on year expenditure within the NHS and allowing senior nurses to have more resources (and be less 'crisis driven') with a more developmental approach in their management of services.

A criticism levelled at the Labour Government is the over emphasis on performance targets in the public sector as a centrally controlled 'top down' process. Central control and direction of the NHS has been a hallmark of this Government (Bradshaw, 2003). A comment from Nick Bosanquet, as leading academic on health policy:

> "There has never been a greater gap between the view of solutions at the centre and the realities as they appear day to day at local level." (Bosanquet, 2001: 395)

This study represents the implementation of a policy dictum at a local level underpinned by a participatory approach to organisational change. There are a number of striking issues to consider in the implementation of this policy framework within this type of setting:

1. The impoverishment and isolation of the service
2. The extremely low levels of staff morale
3. Key issues of leadership development
4. The need for extensive staff development adopting more experiential approaches
5. The amount of investment needed (an I grade nurse for three years) to support change

These are the sobering issues from 'the local level' that need to inform policy makers if the NSF for Older People is to live up to these challenges. At the beginning of the study the rhetoric of policy and the reality of practice in this study did seem far apart. However, the second standard in the NSF for Older People served as a useful lever for change towards improving care.

4.6.4 Commentary on policy initiatives

The purpose of the second standard in the NSF for Older People is to ensure older people are treated as individuals and that they receive appropriate and timely packages of care, regardless of health and social care boundaries (Department of Health, 2001a). The policy rhetoric is about putting the patient rather than the service 'at the centre' (Department of Health, 2000). I have argued earlier, within the literature review on person-centred care, that this policy perspective on person-centred care is heavily underpinned by consumerist principles and has an individualised focus on the person. The policy perspective has been critiqued for being too narrow and not best serving the needs of older people (McCormack, 2001; Nolan et al., 2002). The values of interdependence and mutuality and a more relationship-centred perspective may be a more useful and helpful conceptual framework for older people living with chronic illness (Nolan et al., 2004).

A key aspect of the person-centred standard is that the users' and carers' experiences of health services are captured with appropriate service improvements or changes made in response to this information. In essence, this demands that healthcare staff be better able to listen and engage with users and carers about their healthcare experience and in turn that services be more responsive to need. The results and outcomes of this study illustrate the importance of working not only with users and carers on sharing life stories, but of equal importance is the establishment of parallel systems for staff to be able share their experiences of work. The premise behind this approach is that staff need to feel heard and listened to before being able to listen to and hear the needs of users and carers. In the study this produced a dynamic synergy and supported the change and

development process towards person-centred care. The approach is underpinned by systems theory.

Systems theory as applied to organisational change is based upon the notion that systems are not chains of linear cause-and-effect relationships, but complex networks of interrelationships (Senge, 2004). Activity within the system is, as a result, one element on another and feedback can be positive (amplifying) or negative (balancing) in nature. Events, forces and incidents should not be viewed as isolated phenomena but seen as interconnected, interdependent components of a complex entity (Iles & Sutherland, 2001). From a systemic organisational change perspective, the need to change relationships between staff and patients requires viewing the system as a whole, within which staff need to feel that they are in turn treated in a person-centred way by those around them e.g. colleagues, managers. Clinical supervision for staff teams and action learning for managers as experiential interventions within this study served in a positive (amplifying) way to develop person-centred care and change relationships within the service as a whole. These interventions allowed staff to recount their experiences of working with older people in long term care which in turn released the energy to start to change relationships with patients and family members. A limitation of the individualised approach to person-centred care as advocated in policy through the NSF for Older People is that it fails to adequately delineate the staff and leadership development required to deliver person-centred care and lacks a systemic approach to change. This study demonstrates the effectiveness of experiential small group activities for staff in supporting the change process in improving the quality of person-centred care.

4.6.5 Links to theoretical ideas and the concept of organisational contagion

Drawing on the person-centred literature, the most useful and applicable conceptual framework for this study was devised by the Tresolini and Pew-Fetzer Task Force (1994) on relationship-centred care in the USA. The applicability of their framework of psychosocial dimensions between patients and practitioners, practitioners and across professional groups and with the community was useful because of its systemic and interdependent orientation. This framework was accessible and has been integrated into the presentation of the research findings in the evaluative phase of the study. In the UK,

Mike Nolan and colleagues drew upon the relationship-centred ideas of the Tresolini and Pew-Fetzer Task Force and devised the 'senses' framework to describe the attributes or senses required for high quality care for older people describing conditions necessary for both staff and patients. The senses are: sense of security, sense of continuity, sense of belonging, sense of purpose, sense of fulfilment and sense of significance (Davies et al., 1999; Nolan et al., 2002). In addition, Anstey (2003) argued that there should be a seventh sense of 'expertise'. If the senses are addressed then enriched environments of care exist, whilst impoverishment results if the senses are neglected. Although the senses framework was not used directly in the explication of findings in this study, it did offer an underpinning perspective on the mutuality of experience between staff and patients emphasising the values of community and shared experience. This relational theoretical conceptualisation of care based upon a shared basis of experience between both staff and patients presented by Nolan and colleagues represents a more systemic, interconnected and interrelated description of quality nursing practice, challenging notions of individualism (Nolan et al., 2004). These authors identify a gap in the current literature in 'how to' develop relationship-centred care and this study illuminates the systems necessary to create more enriched care environments.

I believe the limitation of the 'senses framework' to date is its essentially descriptive nature, which does not guide practitioners in how it can be applied to change practice. Drawing on the experiences from this study, the researcher believes psychodynamic theory is a useful adjunct to the senses framework and in particular Melanie Klein's classic theory of projective identification as applied to organisational behaviour by Moylan (1994) and Klein (1975). See earlier discussion on page 135 within the Methods chapter. Projective identification processes are seen as part of healthy development, in which difficult and opposing emotions are projected outwards onto others who take on the emotional attributes of the projected feelings. Klein (1975) describes a set of processes emotionally linking the individual with others and sets out a framework for seeing the interconnectedness of relationships through projective identification. However, if projections habitually remain split off and not integrated, Klein (1975) argues unhealthy psychological development will ensue. From an organisational perspective, the following projective identification processes can take place:

"clients rid themselves of their painful feelings, and also communicate aspects of their experience which they cannot put into words, by projecting them onto staff. This can have a profound effect on a staff group. They too can become distressed and deal with this by projection. The whole organisation can then become caught in the same state of mind as the clients it exists to serve." (Obholzer & Zagier Roberts, 1994: 49)

The important adjunct of psychoanalytic theory to Nolan and colleagues' senses framework is that projective identification processes lead to the 'same state of mind' of staff seeking to alleviate the suffering of clients. This idea of an organisation in the 'same state of mind' as its clients shares a parallel with both staff and patients sharing the same 'senses' of experience as described by Nolan et al. (2002). Psychoanalytic theory sees projective identification processes resulting in healthy (projections integrated and able to tolerate both good and bad 'characters') or unhealthy development (projections remain split off). Moylan (1994) describes the dangers of emotional 'contagion' in organisations in which projective identification processes between staff and patients run unchecked, preventing creativity, thoughtfulness and reducing capacities to engage with the difficult realities of caring for vulnerable, dependent, frail clients. This resonates with Nolan's description of impoverished care environments and indeed seemed to reflect many of the attributes of the nursing home at the commencement of this study. Hence, a tentative theoretical link lies with the 'senses' framework and the descriptions of impoverished environments (unhealthy development with projective identification processes spilt off) and enriched environments (thriving developments in which projective identification processes are more integrated). Indeed Smith's recent studies of emotional labour in nursing advocate multi-model approaches highlighting no single theoretical approach adequately deals with the complexity of the management of emotions in nursing (Smith & Gray, 2001). The link between the concept of emotional contagion and unchecked projective identification processes contributing to impoverished environments warrants further theoretical exploration and examination. The following discussion will attempt to illustrate how I as the researcher became involved in the 'contagious' projective identification processes and how these were worked with and reflected upon in practice. In terms of action research and facilitating change, Moylan (1994) describes ways of working with patterns of projective identification in teams to support better ways of

working to create more enriched environments. This model is built upon psychotherapeutic techniques and applied to organisational consultancy in which feelings evoked in the action researcher/change agent are examined resulting in an understanding of unconscious organisational processes. Moylan (1994) argues this goes beyond just listening but also attending to the atmosphere and feelings evoked. In addition, Moylan (1994) argues the more distressed a client group, the more the unconscious communications are likely to predominate.

The following discussion exemplifies the impoverishment and emotional contagion I experienced as the researcher at the commencement of the project. The situation faced by residents entering the Home usually involves facing a slow, steady physical decline towards death, physical weakness, vulnerability and dependence on others for care. This transition into long-term care evokes potentially primitive human emotions that may be unconsciously projected into the staff. This appeared to be made manifest by the staffs' sense of powerlessness, low morale, apathy and isolation. In other words the staff seemed to have unconsciously entered the same 'state of mind' as their clients. I also enacted this experience. During the first year of the project I feared the 'contagion' associated with the nursing home and was concerned with being 'infected' by the powerlessness and apathy permeating the environment. I felt overwhelmed with hopelessness and anger about this situation. Correspondingly, I was unable to listen effectively to the staff's experience during the first phase of the project and struggled to engage with the realities of the situation. It was through supervision and action learning that I was enabled to understand my emotional responses. By attempting to understand my experience seen as a form of communication connecting to staff and resident experience (through exploring the processes of projective identification), it became increasingly apparent how to approach the intervention and 'action' phase of the study. My ambivalent and fearful feelings were part of an enactment of the organisational dynamics and these difficult emotions should be brought to the surface (if possible) in a safe and supportive way to allow participants to better understand their behaviours. Both staff and residents needed to have the opportunity to 'tell their stories' of their lives and working experiences.

To conclude, the theoretical links between projective identification processes and emotional contagion have been explored with links made to Nolan et al.'s (2002) senses framework and impoverished and enriched environments of care. The experience of the researcher and her engagement with the emotional contagion of this environment was used to try and appreciate the experience of others involved in the study.

4.6.6 The implications of this project

An undoubted question of any change and development project relates to sustainability and embedding of the change process into practice. Certainly some staff at the close of the project raised the departure of the researcher as a concern in maintaining the momentum of change. However, the researcher worked with managers and staff in the organisation to ensure sustainability. This was achieved through the following developments:

- The managerial re-structuring of the Continuing Care Services implemented at the close of the project. Both community and residential Continuing Care Services were combined and the post of Modern Matron created to manage these recently amalgamated services (see earlier discussion in section 4.1.9). The Manager of the Home was successfully appointed to this new post and gained a promotion. From my perspective this was an extremely positive outcome of our relationship together during the research process. In addition as part of the managerial re-structuring, two G grade posts were created to lead the ground and first floor nursing teams. Staff who had been involved in the project both successfully applied for these posts further reflecting the positive relationships established during the project. These three new posts strengthened nursing management and leadership with Continuing Care Services placing the managerial structure within the Home in parity with nursing management structures in the hospital as whole. I believe these additional resources to Continuing Care Services reflected a greater value attributed to this nursing service by senior members of the nursing management team and set up a more robust managerial framework within the Home to support sustainability. The promotion of staff

within the Home created the opportunity for a new impetus and drive for change as the researcher exited the Home. All three research participants accessed NHS leadership development programmes to support them in their new roles. The new roles and leadership programmes created optimum managerial conditions to continue the development of this nursing service.

- Additional resources were secured during the project for part-time occupational therapy and psychology input to the Home. It was agreed with staff that ongoing clinical supervision would be provided by the Psychologist and that the Occupational Therapist would support staff in collecting biographical information with residents. The final DCM was undertaken with the occupational therapist as an observer of the data collection process. The occupational therapist agreed to take the lead on supporting the implementation of DCM recommendations. I ensured an effective handover with these personnel through a detailed handover and perceived a serious commitment to take forward initiatives.

- The researcher's ongoing connection with the Home was ensured through my appointment in August 2004 as Nurse Consultant for Older People. This appointment ensures a continuing relationship with staff and the residents. The Nurse Consultant post spans all services for older people at the hospital, ensuring I am a resource to support ongoing enrichment and development at the Home.

- A further action research project commenced in 2004 to support the development of a learning network between the various Care Homes in the borough. This is led by City University and the Home is an active participant in this new study. The creation of a learning network places the Home in a good position to share with other local Care Homes the learning and practice development initiatives undertaken as part of this project.

My on-going involvement in the Home as Nurse Consultant allows me to report that improvements are being sustained and the Home's reputation in the borough has significantly changed for the better.

4.6.7 Recommendations

The recommendations emerging from this project include:

1. This project's findings support the use of small group experiential activities e.g. clinical supervision and action learning as an important adjunct to activities fostering person-centred care.

2. The most helpful validated tool in supporting the development of person-centred care within this project was QUIS. However, this project has highlighted some practical difficulties in using audit tools as part of developing person-centred care. The tools were useful but relatively limited as compared to the power of the researcher listening to residents, family members and staff experiences in the Home. Unsurprisingly, but nonetheless important to emphasise, is the priority to be accorded to listening and hearing the experience of participants over and above any audit tool usage in the action research process.

3. The impoverishment of clinical areas for older people should not be under-estimated by policy makers if changes are to be real and sustained. There was evidence of sustained improvement in the quality of care provided to older people in this project meeting the agenda laid out in the NSF for Older People (Department of Health, 2001a). However, this change required an intensive developmental programme over three years and the full-time resources of a Research and Development Nurse (I grade).

4. The theoretical underpinnings of this project were psychodynamic and systemic approaches which worked successfully in supporting the development of more person-centred approaches to care. Whilst psychodynamic and systemic theoretical approaches proved successful in this study, to recommend a theoretical 'straight-jacket' out of this project is not the desired outcome. It is merely to emphasise that a systemic and psychodynamic framework was helpful. Other theoretical orientations including the more humanistic approaches of relationship-centred care (Tresolini & Pew-Fetzer, 1994) and the concept of mutuality (Nolan et al., 2004) were highly influential upon the researcher's ideas and analysis of findings concerning person-centred care. The complexity of the emotional life of organisations and the need to enrich many clinical

areas caring for older people indicates multi-model approaches may be most useful (Smith & Gray, 2001). Theoretical developments from clinical nursing, education, psychology, policy, emotional labour and workforce development all contribute to understanding in this field. Such eclecticism enriches and diversifies nursing practice and reflects the complex nature of nursing care.

4.6.8 Conclusion

We are part of a consumerist society with strong values of individualism and autonomy. These values may not best suit the needs of older people experiencing a decline in physical and cognitive faculties, dependency on others and facing the fears of death (Nolan, 2001). Equally, the value attributed to long term nursing care for older people is low and indeed staff morale in this nursing service was extremely poor at the commencement of the study. The 'state of mind' of the staff seemed to directly relate to that of the residents which Moylan (1994) describes as emotional contagion through unchecked projective identification processes. She argues that emotional contagion in organisations results in a lack creativity, thoughtfulness and reduced abilities to effectively engage in the realities of the work. In addition, Nolan et al. (2002) usefully describe both enriched and impoverished care environments through a 'senses' framework emphasising the mutuality and interconnection of both staff and patient's experience in gerontological care. In this study I worked towards exploring the emotional contagion seemingly endemic in the Home through understanding the interconnections between my experience and staff and residents' experiences in order to establish a more enriched environment in which all participants could feel more human and valued.

This study commenced in an impoverished and much maligned service in which staff felt marginalised and misunderstood. However, through the collaboration of residents, family members, staff and managers, effective change and improvement took place. The three main interventions (biographies, clinical supervision and action learning) underpinned by systemic and psychodynamic approaches were powerful strategies to support the change process. The ingredient for success seemed to be helping staff to value themselves in their work to enable them to better care for others. In essence, this

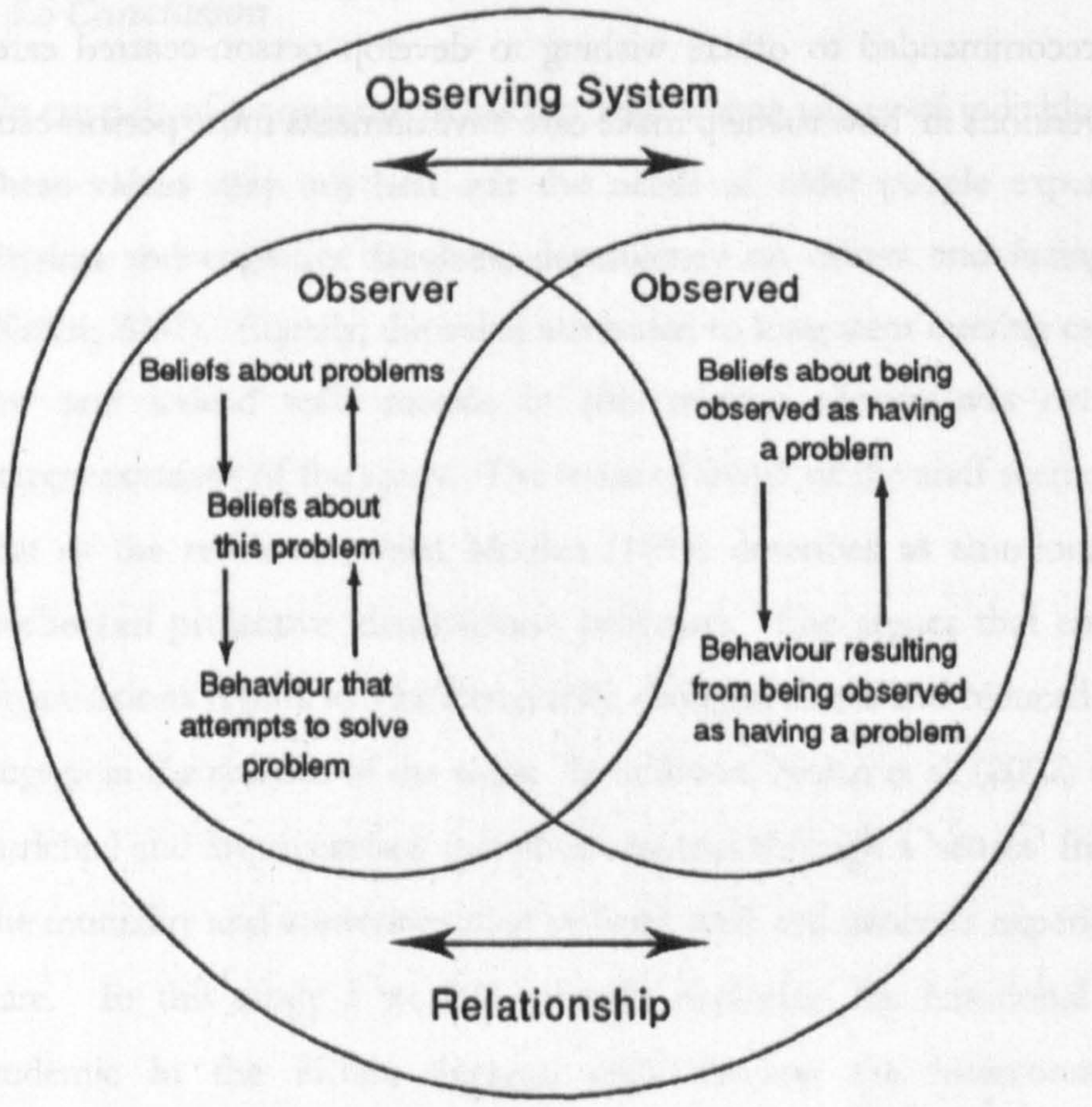
project supported staff, residents and researcher to tell their stories. The learning from this study comes from the systems of staff development (team supervision and action learning) necessary to support person-centred care. This systemic approach of working with both residents and staff yielded positive results and can be recommended to other health and social care practitioners striving for more person-centred services. It is argued that utilising clinical supervision, action learning and biographical interviews in a psychodynamically informed way, allows practitioners to address some of the emotional and organisational constraints that get in the way of changing practice. This model of working can be recommended to others wishing to develop person-centred care and offers some interventions in 'how to' help make care environments more person-centred.

Appendices

Appendix 1: The observing system

1. <u>The observer position:</u>

Diagram One: The observing system (from Huffington and Brunning 1994, p.17)



Appendix 2: Interview schedules

Interview Schedule One Devised February 2002

Questions for interview (staff):

What improvements (if any) have been made over the past 12 months?

How do you feel about the project that has taken place at the Home over the past 12 months? If no changes why is this the case?

Is there anything regarding the project you would like changed for the future?

What do you see as being good care given at the nursing home (standards of care)? Can you give an example?

How would you describe your relationships with residents and family members?

Comments on the environment, food and activities (if not already mentioned)

How do you think care has changed (if at all) for older people over time? How do you feel about these changes?

Reflecting on your own experiences of caring for older people, what changes (if any) would you like made at the nursing home?

Questions for interview (family and friends):

What improvements (if any) have taken place over the past 12 months?

How do you feel about the changes and, if no changes why is this the case?

How do you feel about the care given at the nursing home (what is good care/standards of care)?

What are your relationships like with the staff at the nursing home? (customer care)

What changes in the environment (if any), would you like to see at the nursing home?

How do you feel about the activities provided at the nursing home?

What is your view on the quality of food provided?

What other comments and recommendations for the future would you like to make?

Interview Schedule Two – Exit Interviews (close of the project)

Section 1 – demographic details

Job title

Grade

Gender

Ethnicity

Borough resident?

Do you have far to travel to work?

Have you undertaken any courses recently?

Qualifications:

Specialist qualifications:

How long have you worked in care?

How long have you worked with older people?

How long have you worked in the NHS?

What brought you to work in this area?

What made you choose a care job?

Section 2

Starting Up

Could you briefly describe your involvement in the project? (Reflect this back and make sure I have accurate info to keep this contained – detail will come later)

How did you become aware of the research project?

At what point did you find out about the research project and what your role would be?

How did you feel when you knew you would be part of a research project?

Do you think things could have been done differently at the start of the project to assist with the process?

Getting involved/participation

Overall, how would you describe your experience of being involved with this project (Prompt: good, bad, reluctant but got in to it, mixed feelings etc.)

What were the factors, if any, that helped you get involved in the project?

Were there any factors that made it difficult or actually prevented your participation (prompt: if so what were they?)

Do you think anything else could have been done to assist you in participating in the project? (By the researcher, the trust etc Prompt according to previous answer)

Consent

Do you remember the researcher giving you information about the research and asking for your signed consent?

How do you feel about this? (prompt were you uncomfortable about having to sign something etc)

Do you think that affected your participation?

Person-centred care

Introduce by saying this project has been about developing person-centred care at the Home through resident's biographies and clinical supervision/action learning

Can you tell me if you think this project has helped develop person-centred? If so, how?

Can you tell me what person-centred care means to you?

What barriers exist for you in delivering person-centred care?

Resident's biographies

You said earlier you have done/not done a resident's biography. What do you think about this process?

What do you think is the value in this process?

What are the problems/difficulties in this process?

Clinical supervision

Can you tell me about your experiences of clinical supervision?

Has clinical supervision supported you in developing person-centred care?

Can you describe any problems in clinical supervision?

Can you describe any benefits of clinical supervision?

Personal learning and development

Do you think that involvement in this project has affected your personal learning and professional development? How?

Prompts: Thinking about clinical issues

Knowledge, skills etc

Project achievements

You said you were in .....part of the project. In your view what has been achieved?

Were there any goals not achieved?

Why do you think this was?

Do you think this work will continue at the end of the project?

Would you like to see it continue?

Expectations

At the start of the project what were your expectations of involvement in this research

Have your expectations of involvement in the research project changed over time?

What do you think brought about this change?

How do you feel about it now?

Is there anything you wish had been done differently?

Evaluation of the post

Do you think being involved in this research project has been of benefit to you? How?

Has the post been anything different from other education and practice development post holders you may have worked with? Can you say what that difference was?

Do you think posts like this are a good use of resources?

In terms of service priorities – where do you think that research fits?

Is there anything I have not asked you about that you would like to discuss?

Appendix 3: Principles of procedure for action research by Winter and Munn-Giddings (2001)

Over and above general ethical considerations in research, Winter & Munn-Giddings (2001) identify the following as necessary for the ethical management of action research activities:

1. Make sure the discussions are documented so that the process can be made available to those who are not present.

2. Procedures for decision making need to be negotiated to ensure voices of all participants are taken into account.

3. Make sure all the project work is distributed to all participants. This requires the prior agreement with project participants that their contributions have been accurately described and that they are in a form that can be shared with others. All interpretations need to be checked back and authorised before being circulated. This in turn means that each participant must be enabled to amend his/her contribution.

4. All progress reports must clearly invite participants to make contributions and to make suggestions concerning future developments

5. Differentiate clearly between documents that are confidential to project participants and reports intended for wider publication.

6. Make clear that reports intended for an audience beyond the group of participants will be circulated in advance and information can withdrawn by participants.

7. Negotiate the right of the group of participants as a whole to publish a project report more widely if they wish.

8. If one (or more) of the participants wishes to write up their work as part of a qualification or an assignment, this needs to be negotiated with the group as a whole.

9. Make sure these various principles are drawn up early in the work, so that they are available in the form of a clear statement which can guide potential participants when making their decision on involvement or otherwise.

DISSEMINATION THROUGH PUBLICATION

One paper is included in the dissemination artefact required for the DHealth portfolio. The paper was published in *Illness Crisis and Loss*, an international peer reviewed journal, in January 2004 and presents the key findings contained in the research report. The authors of this paper included key stakeholders in the research project and were Charlotte Ashburner, Julienne Meyer, Barbara Johnson and Cheran Smith. The formatting of this paper is as requested by the publishers.

5.0 Paper based upon the key findings contained in the research report (published in Illness Crisis and Loss)

5.1 Using action research to address loss of personhood in a continuing care setting

5.2 Abstract

This paper describes a three-year action research project, aimed to support staff in recognising and responding to loss of personhood in a continuing care setting. The context of this study was a National Health Service (NHS) nursing home for the long term care of older people. Interventions used to support this development included the collection and sharing of residents' life histories, weekly team supervision meetings for staff, an action learning set for managers, and monthly external supervised meetings for both the action researcher and senior manager.

This paper reports on the processes and outcomes of change achieved and the learning gained from working in a collaborative way with staff. Given that current policy indicates the need for person-centred care (Department of Health 2001a), this study provides a

possible mechanism for putting it into practice, through a systems and psychodynamically informed approach.

5.3 Introduction

This project commenced in January 2000, with the lead author functioning as a research and development nurse, supporting changes in clinical practice through action research.

5.4 Rationale

Older people are a significant proportion of direct and potential users of health and social services in the statutory, voluntary and private sectors, with those over 65 years currently occupying two thirds of all hospital beds (Department of Health 2001a). However, there is evidence that older people experience considerable social and economic inequality compared with the rest of the population, particularly in London (Howse and Prophet, 2000). Further, there are concerns about the quality of health and social care received by older people (HAS 2000, 1999; SNMAC, 2001). The National Service Framework for Older People (NSF) was established to drive up standards and reduce unacceptable variations in health and social care (Department of Health, 2001a). The NSF focuses on rooting out age discrimination, providing person-centred care, promoting older people's health and independence and fitting services around people's needs.

Such milieu of care for older people demanded by policy represents a very significant change from the task focused, de-personalised, mundane and 'heavy' images and stereotypes that are accorded to traditional gerontological care (Nolan, 1994; HAS, 1997; Nolan and Tolson, 2000; HAS 2000, 1999). In consultation with staff, it was decided to focus this study on changes that better promoted person-centred care.

Research into the de-personalisation that occurs in institutions is extensive with Goffman's (1961) study of the systematic removal of the 'self' within asylums, as a seminal text. More recent evidence of the odious persistence of de-personalisation within institutional care was reported by Kitwood (1997), in relation to older people with dementia who suggested that:

> "people with dementia who are in residential care typically spend long periods without any human contact" (Kitwood, 1997 p.49)

Although Kitwood's work focused on older people with dementia, his work is applicable more widely and has significantly influenced policy makers.

From an organisational perspective, the de-personalisation frequently associated with institutional care can also transcend the patient/professional divide. The individual contribution of the professional may also be negated and de-personalised (Menzies Lyth, 1988; Kitwood and Benson, 1995; Kitwood, 1997). Hirschhorn (1997) suggests staff cannot be expected to provide care, which is based upon dignity and respect; if it is not part of the overall culture of work life and endemic in how teams work. Positive cultures of care for older people are associated with staff who feel well supported and appreciated, along with effective leadership (Nolan et al., 2002). However, it is not clear how to achieve these cultures, particularly when staff are feeling undervalued and demoralised.

This project strived to create a more enriched care environment through a psychodynamically informed approach. This new style of working within the care home setting, simultaneously fostered person-centred care and better relationships between staff and with residents and relatives.

5.5 Local Context

The nursing home was a purpose built facility, which opened in 1995 in an ethnically diverse and deprived area of London. Both staff and residents had been re-located there from long-stay geriatric wards. Residents living in the home were aged over 65 years old, highly dependent with chronic and enduring illnesses. Immobility, incontinence, feeding and swallowing difficulties and cognitive impairment were the main determinants of admission into the home. From a curative biomedical perspective these people can represent 'the worst' that modern medicine has to offer – survival, but far from cured. Nearly all people permanently living in nursing homes die in residence. The home in essence provided long-term palliative care. Terry (1997) argues that the spectres of deterioration and death are subsumed in the innocuous words of 'continuing care'.

There were forty-six nursing staff in post, including seventeen (35%) registered nurses. Staff turnover was not high. Sixteen staff members had worked within the NHS for greater than twenty years and 45% were close to retirement. The staff group was ethnically diverse (43% black Caribbean, 30% black African, 20% Indian and Asian and 5% white European), caring for a predominantly white client group (61% white European, 29% black Caribbean, 5% black African, 5% Indian and Asian).

At the beginning of the project, staff were informed that a research and development nurse undertaking an action research project would be part of a new organisational structure. In essence, there was no choice in having the researcher in the nursing home. This saw the coming together of a keen and enthusiastic researcher with a sceptical and suspicious staff group, who had not been consulted or given a choice over the researcher's arrival. A complex and paradoxical start to a project espousing the values of person-centred care.

Senior management had a number of financial and managerial concerns including issues of over-staffing, inflexibility of service provision, poor cleanliness within the home, environmental problems, security issues, and isolation. In addition the nursing home was off site (approximately three miles) from the main hospital. The staff felt misjudged, victimised and undermined by outsiders. They identified their own strengths as being a stable nursing workforce 'who know the ropes', with time to talk to residents and get to know them. They suggested their weakness lay in the monotonous routine, which caused difficulties in motivation and apathy towards making things happen. They reported tensions between registered and unregistered staff and a sense of vulnerability over nursing homes being generally 'sold off' to the private sector. Staff were in the invidious position of recognising the need for change but, feeling resentful it had been thrust upon them through the arrival of an outside researcher.

5.6 Methodological approach

Although action research is not necessarily the most suitable choice in all settings, Hart and Bond (1995) consider it particularly appropriate when problem solving and improvement are on the agenda. In particular, action research can be useful in the face of scepticism (Pasmore, 2001).

Coghlan & Brannick (2001) identify three common attributes of action research. First, the approach is participatory whereby research subjects are themselves researchers, or in a democratic partnership with the researcher. Second, the research itself is a force for change and the third attribute being that the actions make a difference to those directly involved and the wider community. The spectrum of approaches to action research is diverse (Hart and Bond,1995) and the approach taken in this study attempted to integrate group relations theory, psychoanalysis and open systems theory to learning from experience and understanding organisational life (Gould, 2001). There were two main tenets:

1. The structural systems in which people work impact on behaviour. This includes the division of labour, levels of authority, the nature of the work, the task and mission of the organisation, and transactions across boundaries. These affect individuals in significant psychological ways. Exploring and understanding these influences can positively support organisational understanding and learning (Gould, 2001).

2. Psychoanalysis provides a range of mental processes (e.g. transference, resistance, projection and social defence systems) in which the emotional life of groups and individuals can be understood. The process of working through issues integral to a 'classic' therapeutic relationship is applied to the collective social defences (Menzies Lyth 1988). This may create opportunities for learning and development. Awareness and insight through acknowledging and understanding difficult feelings is seen to be a hallmark of good professional practice (Hawkins and Shohet, 1994).

These main tenets of systems and psychodynamic theory were integrated to the diagnosing, planning action, taking action and evaluating spirals of action research (Coghlan & Brannick 2001), through various systems of clinical supervision and action learning that promoted active reflection on organisational and emotional constraints to changing practice. The action researcher was well placed to take this work forward being trained to masters level in organisational consultancy, using psychoanalytic approaches.

For clarity and simplicity, the story of the process learning and outcomes of the project will be told in relation to the three phases (exploration, intervention and evaluation).

5.7 Exploration phase

During the exploration phase, the researcher worked with a health care assistant one nursing shift per month, as a participant observer, to 'get a feel' for the home and meet staff and residents. During this time the researcher noted the unrelenting routine of the work, the physical focus of nursing care, her own fears of working with highly dependent and vulnerable residents, the overwhelming heat in the home, the smell of incontinence, the shabby and dirty environment (e.g. chipped and mismatching plates and dirty wheelchairs), the lack of visitors and strained relations between staff and family members.

During the exploration phase, regular supervised monthly meetings were established with the lead nurse of services for older people and the researcher. The purpose of the meeting was to explore organisational and emotional constraints to changing practice, in line with the systems and psychodynamically informed process of action research being undertaken. The manager gave the researcher freedom to work with all grades of staff. Staff were asked by the researcher to identify what they wanted from the project and the strengths and weaknesses of working in the home. A number of areas for development were identified (see Table 1).

Table: 1 Areas for improvement in the nursing home identified by staff (see at the end of the paper)

Areas to be improved identified by staff:
1. Better equipment e.g. more hoists
2. More recreational activities for patients e.g. going away on holiday
3. Health Care Assistant education – 'responsibility issues'
4. Working with relatives - how to cope with them
5. Bereavement - better understanding
6. Closure of life - improved palliative care
7. Infection Control - better hand washing
8. Lots of pressures – feel like we have to be in two or three places at once
9. Team working - more open and honest relationships
10. Clinical supervision - never had it
11. Performance management - current systems not working

The focus of staff consultation was on what staff wanted to change. This was not necessarily problematic, but rather missed the pressing issues on how staff felt about the presence of the researcher and their concerns and misgivings about the project. These important issues were not addressed during this phase. One staff member reflecting on this phase said:

> 'The staff needed to tell you what they had been through. The staff should have had an opportunity to tell their story, to get a feel for what the past five years had been like." Interview 1.3 p.2

The researcher was a white relatively young researcher entering into an environment of experienced and mature black staff. Resentment and misgivings were high and evoked comments like 'what is a young high flyer like you doing here?' One staff member's reflections on this period was:

> "I thought you would be spying and looking at how we worked ... I was very wary and I had my doubts ... Was this about to meddle in our business or stir up trouble? I thought it would go back to the higher people and would have nothing to do with patient care." Interview 2.4 p.1

Nonetheless, this phase brought issues out into the open that could not be ignored. In particular, it became apparent that staff were working in a highly routinised way and struggling to value residents' personhood. Furthermore, there were difficulties with relatives and who were not actively encouraged to be involved in care at the home. In addition, staff felt marginalized and isolated within the organisation and had lost the motivation to initiate change. A staff member described how she felt at the beginning of the project:

> "... knocked left to right ...we were sold badly from the outside ... the staff were very demoralised ... the bosses from outside had trashed the place ... it was bad. There was a lack of trust." Interview 1.3 p.1

However, despite these initial feelings, support and encouragement was offered and improvements made, through the intervention phase.

5.8 Intervention phase

Within the intervention phase, there were four main cycles of research activity:

Cycle 1: Promoting person-centred care

Cycle 2: Developing user and carer involvement

Cycle 3: Engaging with psychodynamic and systems thinking

Cycle 4: Sharing and supporting good practice

5.8.1 Action Cycle One – Promoting person-centred care

Having established that residents were not being seen in a person-centred way, this action cycle focused on assisting staff to get to know the residents better as individuals. Staff were invited to identify a resident whom they wished to know better. The resident was then approached and permission sought to interview them, as part of the project. Family members were involved at the resident's behest or in the face of communication or cognitive difficulties. Interviews took place in private and lasted 1.5–3.5 hours. Whenever possible photographs were shared and discussed. Twenty-one residents' life stories were collected over two years. With permission a biographical booklet was written up concerning the story told.

The staff member shared the story and experience with other staff in weekly, facilitated team supervision meetings. The purpose was to engage the team in learning more about the resident and to consider how this may relate to nursing issues.

Discovering and sharing people's life stories was humbling, fascinating, sad and at times a 'real eye opener'.

In addition to the residents biographies, person-centred care training and dementia care audits took place. This latter activity demonstrated the need for more engagement and stimulation for residents. A social care group was established and funding obtained for qualified psychology and occupational therapy input. The biographical approach to care bought improvements in the relationships between staff, residents and family members.

5.8.2 Action Cycle Two – Developing user and family involvement

Audit, interview and participant observation data at the beginning of the project revealed tensions between staff and resident's families. In order to foster better relationships, it was decided to involve them in the decisions about what was needed in the home. A quarterly forum for residents and their friends/family members was established.

Twenty-four semi-structured interviews, regarding changes and developments in the home, were carried out from April 2002 – July 2002 including staff (n=12), residents (n=3) and family members (n=9). Both groups agreed that since the commencement of the project there had been certain improvements, particularly in relation to the cleanliness

of the home. However, the pace of change was considered slow. Interestingly, both staff and relatives had mirrored views of each other. Whilst both groups described good individual relationships, each reported the other to be at times unfriendly, disinterested and having uncaring attitudes.

The 'spin offs' from this activity included regular surgeries for residents' relatives to consult with the nursing home manager. In addition, staff also began to discuss openly difficulties in team working and sought systems to try and address problems e.g. allocation of work in pairs.

5.8.3 Action Cycle Three - Engaging with psychodynamic and systems thinking

Attempts to foster person-centred care and engage with residents created a strong emotional reaction in staff, which seemed to indicate the need for a psychodynamically informed approach. The institution could be described as a waiting room for death. It seemed a twilight place between life and death. It was the sense of apathy and decay in the face of death that felt so exhausting. The life histories were about life and painfully reflected losses experienced. The interviews were inevitably emotional for everyone. This level and type of engagement felt very different from 'an activities of daily living' nursing culture. This culture does focus on physical losses but rarely on what this means in the context of a person's life. Trying to establish this approach to care proved extremely difficult.

The report of the interview findings with relatives and staff (see action cycle two) also caused a strong emotional response from staff, but also a recognition that issues needed to be wrestled with and worked upon. The feedback was taken less as 'a personal attack' from the researcher and staff were much more able to engage in an open dialogue, where difficult and thorny issues could be discussed. This was due to a number of initiatives (clinical supervision and action learning) that were established to encourage reflective thinking in a safe environment. The focus of this work was to address the organisational and emotional constraints of changing practice.

In total, the researcher facilitated 104 small group meetings for 4-12 members. There was an open agenda in which staff could raise issues relating to their experiences at work. The meetings opened with a brief review of the previous week's discussion. Staff brought issues and challenges encountered in their practice. Before leaving they were encouraged to identify actions that might be needed to resolve issues and were invited to report back on developments at the next meeting. Attendance at these supervision meetings was generally good, although not always consistent due to the irregular shift patterns worked by staff.

A content analysis of the main focus of discussion at each team supervision session is shown in Table 2.

Table two: content analysis of team supervision sessions

Focus of discussion	Frequency	%
Presentation of a life history	21	20
Working with relatives	19	18
Team working	17	16
Death	13	12
Behavioural difficulties of residents	07	07
Environmental issues e.g. cleaning	05	05
Clinical care	05	05
Psychosocial activities e.g. parties	05	05
Food quality	03	03
Professional accountability	03	03
Review meetings e.g. ground rules	03	03
Changes in elderly care over time	02	02
Child care issues	01	01
Total	**104**	**100**

These sessions formed the backbone of the project and supported successful changes across a wide range of initiatives e.g. from improved relationships between staff, residents and family members to the cleanliness of the nursing home.

However during the first year, the researcher became conscious that she was working 'against' rather than 'with' staff and concerns were expressed about the researcher's role. It proved to be a 'turning point' in the project and brought energy and vigour to activities in the second year. In particular, it allowed relationships to be renegotiated. The researcher became more facilitative and in so doing, the researcher started to work in a

person-centred way with her colleagues. Difficult feelings and tensions were openly discussed, through the supervision meetings. Trust and respect was built over time, supported by the managers who positively encouraged staff to work within the project framework. This change was hard won but it reaped many positive changes.

5.8.4 Action Cycle Four – Sharing and supporting good practice

As time progressed, the nursing home staff felt proud of the changes they were making and wanted to share their experience with others in the Trust. Staff in the nursing home felt less isolated from their peers in the hospital. This was represented by a staff member saying:

> "before the hospital took over, we were in the shadows, we are part of an organisation and we never had this before" interview 2.2 p.3

The launch of the National Service Framework for Older People (Department of Health 2001a, 2001) raised the profile of older people services within the trust and staff were encouraged to change their practice in light of the new standards and to share their experiences with each other. With this in mind, a local steering group for the project was established. Valuing the efforts to change and raising the profile of the nursing home within the organisation was seen as important in the eventual success. This culminated in a presentation to the Hospital Trust Board concerning the achievements made in the nursing home over the three year period. Staff reported feeling externally validated and as one staff member said:

> "We are doing well, we have a different model, but we address the nitty gritty" interview2.6 p.2

In addition, an action learning set was established for managers working in elderly services to come together and develop their leadership skills. The manager of the nursing home was now familiar with this reflective style of working and able to make a valuable contribution to the group. Group meetings were well attended over two years. The action learning set met for a day, every month, and members presented for approximately one hour on a work issue of their choice. After each hour, action points were agreed and reflected upon in subsequent meetings. Leadership development was seen as key to

supporting changes in the service. The researcher co-facilitated this group with another colleague and both were members of their own action learning set. Again, there was a focus on exploring the emotional and organisational constraints to change, supporting the psychodynamically informed action research approach.

The action learning sets fostered a growth in confidence. In particular, through the process, set members recognised and valued their own strengths and felt more able to change practice. One member stated:

> "I have presented out of my comfort zone but it has offered a different perspective on life, and the challenge has been very positive. Professionally, I feel as if I have grown up." Interview 1.2 p.4.

This was required to support personhood in others and build collegial relationships.

5.9 Evaluation Phase

This final phase involved a repeat of the baseline audit, using the shortened quality interaction schedule (QUIS) (Dean, Proudfoot, and Lindesay, 1993). This included eight observations of fifteen minutes duration, undertaken in communal areas, over a period of 48 hours undertaken at the explorative and evaluative phases of the project. Communication between staff, residents and visitors was rated into four categories: negative, neutral, basic care and positively social. Significant improvements in the quality of interactions were found. Table 3 summarises these changes.

Table three: Changes in QUIS scores (December 2000 – January 2003)

Coded interaction	Frequency December 2000	Frequency January 2003	% Change
Positive social interactions	9 (10%)	31 (18%)	+ 8
Basic care interactions	46 (51%)	126 (74%)	+ 23
Neutral interactions	25 (27%)	13 (8%)	- 19
Negative interactions	11 (12%)	0 (0%)	- 12

Positive social interactions increased by 8%. A higher percentage of communication (74%, as opposed to 51%) was focused around caring activities. No negative social interactions were recorded (a comparative reduction of 12%). In addition, neutral comments were substantially reduced form 27% to 8%. Interestingly, there was substantially more communication coded in the second audit (170 interactions, compared with 91).

In addition, twenty-two interviews took place with staff reflecting on their experiences of the project. In general, staff valued the role of the researcher as expressed below:

> "It has been a breathe of fresh air, a life line, it has brought a bit of life to the home and it has made me see that they are interested in us here and also the carers and relatives." Interview 2.6 p.6

Overall, staff felt that there had been improvements and the majority stated that they were feeling happier at work.

> "Skills have come to the surface and I mean my communication skills and my confidence.... it has been about really understanding my work. I am happier in my work – this last three years I have been a lot happier." Interview 3.4 p.4

Staff reported knowing residents better, but this was not without an emotional cost. As one member reported:

> "Relationships have grown during the project ... they [residents] become part of your family. This makes the death hard ... then it hits you like part of your family ... it hits you. Colleagues need to understand the loss ... over the years she was not just a resident. It is no good saying you must not get attached, when they are ill, the love you feel for them is there and you want to protect them more. Seeing the deterioration (pause) watching it is heart breaking." Interview 2.1 p.2

Over time, death was more openly discussed, particularly through clinical supervision sessions. This usually came up as a staff member describing a funeral they had attended or events at the home to mark a person's death. Through discussing and thinking about

death, paradoxically, staff were more able to think about life and personhood. However, the difficult and painful emotions of getting to know somebody better and then watching them slowly deteriorate and die may cause an unconscious emotional 'backlash'. In this study the staff spoke positively of the process of getting to know residents in their care. However, they also perceived difficulties with regard to relationships with colleagues and residents' relatives. Strong angry feelings were evoked. Psychodynamic understanding offers the theoretical concept of projective identification in which difficult emotions e.g. anger and frustration over death and deterioration are unconsciously transposed to others (Halton, 1994; Moylan, 1994). This is an area worthy of further research.

5.10 Conclusion

Whilst the person-centred standard in the NSF for Older People (Department of Health 2001a, 2001) challenges negative stereotypes, it presents a limited vision (Nolan et al., 2002). For instance, it does not acknowledge the need for staff to feel valued as individuals in order to deliver person-centred care. Kitwood and Benson (1995: p10) suggest:

> "staff can only give person-centred care to others in the long term, if their own person hood is acknowledged and nurtured."

In preference to person-centred care, Nolan et al. (2002) advocate relationship centred care in which the focus is upon the relationships that form the context of care (Tresolini and Pew-Fetzer Task Force, 1994). The findings from staff interviews in this project clearly identified certain relationships (between relatives and colleagues) as barriers to developing person-centred care. This defined the limits of the project's success. Findings generated from this study thus support Nolan et al's (2002) thesis of the limitations of the individualised view of person-centred care in current policy and the need for more systemic relationship focused approaches. It is argued that utilising more psychodynamically informed processes, such as clinical supervision and action learning, allows practitioners to address some of the emotional and organisational constraints that

get in the way of changing practice. These approaches are seen as key to developing relationship centred care in the future.

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